NHS
Camden and Islington
NHS Foundation Trust

Annual Report and Accounts 2016/17

Camden and Islington
NHS Foundation Trust

Early and effective intervention • Helping people to live well • Research and innovation

Camden and Islington NHS Foundation Trust

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Contents

Contents

(cont.)

Celebrating Eid at the Trust's inaugural BME Staff network meeting

1

Chair's Welcome

Foreword by Leisha Fullick, Trust Chair

In the last 12 months I have been delighted to see that the stigma attached to mental health has been widely challenged by many high profile opinion makers and leaders.

There has been a huge emphasis on encouraging people to talk about their mental health and a much greater recognition that our mental wellbeing is just as important as our physical wellbeing.

Justice demands that the one in four of us with mental health problems have the right to the same levels of support as those suffering from any other sort of illness, and hopefully the public debate will mean greater recognition and support for services like ours.

In the context of this important debate, we are proud that our clinical skills and research excellence have put us at the forefront of developing better services and care for those with mental health conditions.

In the last year, for instance, we have continued to work with our Clinical Commissioning Groups on our Integrated Practice Unit project to develop more effective ways to look after people's needs in an increasingly holistic way. This has meant that, uniquely for a mental health trust, we are co-ordinating our service users' physical health needs, in collaboration with our primary care and acute trust colleagues.

Another example of the innovative community work we have been doing is leading, on behalf of NHS England, a two-year trial in Islington where our specially-trained staff in the Individual Placement Support service have been offering help to people with long-term mental and physical health conditions who would like to get back into work, but need more intensive help to do so.

The Trust has also worked hard this year to develop plans for the future of all our services to ensure they will meet future needs and demands and that we are able to continue to provide the best possible care. We have been giving a lot of thought to what our Trust will look like in the future, what its priorities should be and how and where services can best be provided.

The options being explored include redeveloping our St Pancras site, improving our community mental health facilities and bringing our academics together on a single site at St Pancras in world-class research facilities.

Our priority, of course, is always our service users and during the last 12 months there has been detailed work to ensure that they will be at the heart of these plans and of everything we do.

We see co-production - working in an equal partnership with our service users - as vitally important, and we have produced a new "Service User Involvement Strategy" which outlines how we will engage service users much more closely in shaping, planning and monitoring what we provide.

Service users contributed a great deal to the life of the Trust in the last year. Several kindly devoted time to speak at some of our regular "Mental Health Matters" meetings (formerly known as "Medicine for Members" events), where they provided personal insights into topics such as stigma in mental health, race equality in the NHS and quitting smoking.

And, through the support of a Council of Governors' fund, there have been a number of other projects where service users have been actively engaged. These include the establishment of a successful community choir, a women's exercise group and a gardening project at the Crisis House on our St Pancras site. The choir gave memorable performances at both our late summer Open Day and our Christmas carol concert.

There have also been a number of great developments this year involving staff. I was particularly delighted to be involved this last autumn in the launch of the Trust's new BME (Black Minority Ethnic) Staff Network - "Network for Change" - which aims to ensure fair representation and equality of opportunity in the workplace. The network is going to be enormously important in recognising and celebrating the diversity of our organisation and helping us to make sure that all staff feel valued and engaged and are represented at every level in the organisation.

Our wonderful staff are the lifeblood of the Trust and I cannot thank them enough for their dedication and hard work. I am hoping that our new "Our Staff First" initiative, also launched in the last year, will soon show real results in developing better training and support and offering wider development and career opportunities for all.

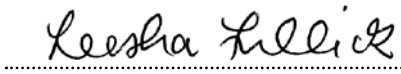
With the issue of mental health so under the spotlight, we have been proud to host regular visits by local and national politicians and national health bodies, to learn further about our Trust and our clinical expertise.

Our visitors have included Health Secretary Jeremy Hunt, Labour leader and Islington North MP, Jeremy Corbyn, and Holborn and St Pancras MP Sir Keir Starmer. There have also been visits from health bodies including NHS England, Public Health Wales, and the Health Service Executive in Ireland.

This year, sadly, we said goodbye to Richard Brooman, our non-Executive Director for Audit and Risk, who came to the end of his term of office after serving the Trust Board well for eight years. However, we have had the opportunity to welcome two new colleagues, Professor Tom Burns and Kieran Parmar as non-Executive Directors, who are already making a great contribution to our Board team.

Finally, I would like to congratulate Angela McNab on a very successful and energetic first year as our Chief Executive. She has made a huge and positive impact in a very short time, and I look forward to continuing to work with her and the rest of the Board to ensure what I believe is a very bright future for the organisation.

Yours



Leisha Fullick
Trust, Chair
26 May 2017

We are proud that our clinical skills and research excellence have put us at the forefront of developing better services and care for those with mental health conditions.

2

Chief Executive's introduction and overview of performance

Angela McNab, Chief Executive

It has been an extraordinarily busy, but also incredibly successful, 12 months for everyone at the Trust and going forward the pace of change looks set to continue. Given how much is going on, it is a good time to reflect on what has been achieved and to look forward, positively, to the plans we have for the coming year.

This has been my first year with Camden and Islington Foundation Trust and I have really enjoyed meeting so many staff and service users, seeing the fantastic services that we deliver and engaging widely across the boroughs to further improve mental health. I have been very struck by how much people have gone out of their way to welcome me and delighted to see how keen people are to share ideas, work together and influence future developments.

We have spent a lot of time agreeing our key strategic priorities: Early and Effective Intervention; Helping People to Live Well; and Research and Innovation. It has been heartening to hear how aligned we are in the Trust. Building on that work, we have collectively identified how we want to see our culture develop to make Camden and Islington Foundation Trust the very best place to work and the place where we can all achieve our aspirations. I am looking forward to seeing this work deliver real change in the coming year.

One of the pillars of our culture change programme is to empower everyone to take action and make positive changes where they can see how things could be improved. To support this, we have launched a system of quality improvement and the training is being rolled out across teams in the Trust. This will facilitate teams, locally, to identify issues and make changes that improve care. This approach will also support addressing some of the areas identified in our CQC report last year. We were pleased to see clear recognition of the outstanding work done in our older people's services and of the caring culture in our Trust, but we recognise there are some areas in operational services where there is a need for more consistency.

The CQC report also highlighted the problems with our buildings, particularly at St Pancras. We have worked hard this year to identify what estates and facilities we need going forward to support us achieving our clinical strategy and we have begun recently to meet staff, service users, carers and other stakeholders to hear what matters most to people.

We have a great opportunity in redeveloping St Pancras to not only address the inadequacies of those buildings but to create better integrated services in the community, closer to primary care and enabling more joined-up support for people. The coming year will see this planning accelerate as we consider the options.

Integrated care is central to the Five Year Forward View and to our own clinical strategy, and one area where we have led this approach is in supporting individuals with psychosis. In January 2016 we were awarded lead provider status for the creation of a service known as the Integrated Practice Unit, aimed at increasing the life expectancy of people with psychosis, by tackling their long-term physical health conditions. A year on, I am delighted to report we are showing good results already from the initiative, with 10% of service users who are involved, no longer smoking thanks to the support they receive. The future expansion of the programme will put us on target to reduce the suicide rate among patients with psychosis by 20% by 2022.

During the last year, as you know, all the main healthcare organisations and local authorities across England were asked to come together into local systems and make plans to ensure the best use of resources to deliver high quality and sustainable services in the years to come. The Sustainability and Transformation Plan (STP) for north central London was published in October 2016 in draft. The mental health workstream focuses on earlier intervention, more support for those in crisis and providing more local care, setting up a female PICU, for example, where none currently exists across north central London.

We recognise these actions are the right thing to do and will also help sustain resources across the patch. Our own finances have continued to be in a positive position, although we have, like all Trusts, found managing the budget more challenging. In particular, the difficulties recruiting across London mean we often have to engage temporary staff at more cost and we are actively working on positive programmes to build our own talent and to ensure we offer staff opportunities to develop and a sense of real value.

One of the ways we offer more opportunities to staff is in being part of research and Camden and Islington Foundation Trust has an enviable position with research compared with most trusts across England. We see research into practice as a key priority and will increase our facilities for research in our St Pancras redevelopment programme. Key research studies published or underway include really exciting work by Professor Gill Livingston which has been shown to cut depression among individuals caring for a loved one with dementia, by offering psychological therapy in the form of coping strategies. This is now being rolled out more widely across the Trust – a prime example of research being turned into practice. I am very excited about the future potential from research which you can read much more about later in this report.

I am equally confident about the future for the Trust's plans. We have a very full and challenging programme for the year ahead but one which I know is going to see real improvements and developments across Camden and Islington. I should like to thank all the staff, governors, service users and carers for their engagement and hard work over the last year and look forward positively to working together in 2017/18.

Yours

Angela McNab
Trust Chief Executive
26 May 2017

> One of the pillars of our culture change programme is to empower everyone to take action and make positive changes where they can see how things could be improved.

3 Performance Report

3.0 Performance report overview by the Chief Executive

Further to the Chief Executive's overview, this section of the report provides a short summary of the Trust, our purpose, and how we have performed during the year.

3.1 Brief history of Camden and Islington NHS Foundation Trust and our statutory background

We are a strong performing, ambitious organisation. Our focus is on providing high quality, safe and innovative care to our patients and their families.

We provide mental health and substance misuse services to people living in Camden and Islington, and a substance misuse and psychological therapies service to residents in Kingston.

We have two inpatient facilities, at Highgate Mental Health Centre and St Pancras Hospital, as well as community-based services throughout the London boroughs of Camden and Islington, and in Kingston. Our Trust is also a member of University College London Partners (UCLP), one of the world's leading academic health science partnerships.

We provide services for adults of working age, adults with learning difficulties, and older people in the London area either in a community or inpatient setting.

Our income for 2016/17 was £139 million and we have approximately 2,000 staff. Our staff work in multi-disciplinary teams providing a holistic approach to recovery. This means that we often work with partner agencies and the voluntary sector.

Camden and Islington Mental Health and Social Care Trust was established in 2002. In March 2008, we became the first Care Trust to achieve Foundation Trust status and are licensed by NHS Improvement.

Over the last year, we have seen continued success in delivering high quality services to our patients and carers. We have also further developed our systems for assurance and improvement. Further details of these achievements are provided in the Trust's Quality Report contained in section 5 of this annual report.

Through our academic partnership with University College London, we have a strong reputation for supporting world-class quality research into mental health.

Health Secretary Jeremy Hunt hears from Trust staff about the challenges of working in mental health

3.2 Mental health need

Camden and Islington covers an area with a rich mix of diverse ethnic and social backgrounds, from wealthy celebrities, politicians and overseas visitors at one extreme, to areas of poverty and social housing at the other. The rich and the poor live adjacent to each other and not in pockets.

There is such a mix of populations that more than 290 languages are spoken by the people we serve.

Our area has some of the highest needs for mental health services within the United Kingdom, with a high prevalence of mental health problems and substance misuse.

Islington has the highest prevalence of psychotic disorders in England, nearly double the national average, and the highest prevalence of depression in London.

We serve challenging groups and a transient population of young adults, particularly students and young professionals moving into London, who are highly mobile.

As a consequence, around 40% of inpatients are new to us each year, which makes special demands and has direct impact on the services we provide and the skill set of our highly trained staff. Our teams are adept at working within the highly varied cultural composition of our boroughs and in managing the transient nature of some of our service users. We factor in the challenges this presents in our overarching service provision and the daily care that we provide.

We have shaped our services in direct response to the profile and needs of our community and, as a result, are at the forefront nationally and internationally in our approach to areas of mental healthcare. This includes our Early Intervention Service, Assertive Outreach work, crisis teams, dementia care, embedding mental health teams in GP practices, caring for physical health in psychosis, and our memory clinics in our Services for Ageing and Mental Health.

3.3 Our purpose and activities

3.3.1 Our vision and strategic aims

The success of any organisation starts with being able to identify what its focus should be long-term.

Over the last year, we have worked hard collectively to decide what Camden and Islington NHS Foundation Trust's focus should be, with the following three, key priorities now agreed:

Our key priorities

01
Early and effective intervention

02
Helping people to live well

03
Research and innovation

Our next step has been to pinpoint how to achieve these priorities. We all face a multitude of challenges at work every day, and the culture we create can make these challenges positive, or overwhelming.

Our staff have provided crucial feedback that there are four cultural steps – or pillars - that are vital if we are to achieve our three strategic priorities.

They are:

C&I's Four Cultural Steps

C&I's Four Cultural Steps

1. **We value each other**
   – this involves supporting each other's wellbeing and development
2. **We are empowered**
   – this means taking action and responsibility to do what is best for your services and team
3. **We keep things simple**
   – this means cutting out bureaucracy when it adds nothing
4. **We are connected**
   – this means working collaboratively across services and organisations, rather than in silos

The goal in 2017/18 is for each staff member to work out how to make these four pillars a reality in their particular area. In turn, these steps support our three strategic priorities – the things we want to be renowned for doing extremely well and that cement our reputation.

3.3.2 Our research

We have a very strong track record for helping drive world-class research on mental health through our academic partnership with University College London.

During the year, we developed this vital area of the Trust's activity, putting it at the heart of everything we do. This has been enshrined with Research and Innovation becoming one of our three key strategic aims.

We have also made significant progress in setting up a jointly-created Institute of Mental Health, with seminars highlighting key UCL/C&I research and insights into mental health.

Our leading academic clinicians are jointly appointed by the Trust and UCL and currently five of them are Senior Investigators, appointed by the National Institute for Health Research (NIHR).

In the last 12 months, we have again become the top recruiting mental health Trust across North Thames for study participants, with 1,507 service users recruited to our research studies, compared with 1,097 the previous year.

Our academics continue to attract a high level of grant funding and in 2016/17 won additional research capability funding (RCF) of around £700,000. Mental health has recently been included as a theme in UCL's Biomedical Research Centre, attracting funding of £2 million over five years.

Our research has had an impact in many practical ways, influencing clinical practice and guidelines.

For example, David Osborn, Professor of Psychiatric Epidemiology at UCL and a C&I clinical consultant, examined the risks of heart disease and diabetes among service users with schizophrenia and other forms of psychosis.

His findings helped explain the much lower life expectancy in those with mental health illness and led to new guidance on monitoring physical health and appropriate prescribing of antipsychotic drugs.

Below are further examples of recent and ongoing research into practice:

- Our DOMINO trial showing that stopping cholinesterase inhibitors - drugs used to treat patients with severe dementia - was harmful to cognition and made people more likely to enter a care home over the next year.
- Research showing a reduction in depression among those caring for a loved one with dementia, through psychological therapy in the form of coping strategies for the family carer. Over an eight-month period, the START scheme significantly improved the mental health and quality of the life of the carer, for up to five years.
- A study showing that patients with bipolar disorder, who were prescribed lithium, had reduced self-harm and unintentional injury rates.
- Another Trust study has demonstrated the long-term effectiveness of Cognitive Behavioural Therapy (CBT), given to patients whose depression has not responded to antidepressants.
- An ongoing study is looking into which patients would benefit from being prescribed antidepressants and which might be better off without. With the number of antidepressant prescriptions having doubled since 2005, at an estimated cost to the NHS of £780,000 a day, the trial aims to provide better guidance to GPs and patients about when, or if, antidepressants might be beneficial.
- Research into the clinical and cost-effectiveness of a psychological intervention designed to help parents of children with learning disabilities manage their child's challenging behaviour with simple and practical strategies.
- C&I has become one of the first mental health trusts in England to demonstrate the wide scale potential of a new database capable of supporting large psychiatric research projects. The Clinical Record Interactive Search (CRIS) database enables anonymous information about patient outcomes to be analysed on a mass, generalised basis for projects that would otherwise be impossible. The database currently uses anonymous details of 110,000 individuals and, for example, is being used to see if there is any difference in how service users treated at the weekend fare compared to those treated during the week.

Within the Trust there has been wider strengthening, too, of our research culture, with funding for academic fellowships and for consultants to become Principal Investigators.

We are encouraging much wider participation by service users in our research, by explaining to staff how they can facilitate them being recruited to trials. Service users are involved in reviewing key research projects, including also the CRIS research work. We are also raising research awareness with regular updates, announcements and features via our internal communications channels.

Research Associate, Nomi Werbeloff - the Clinical Record Interactive Search (CRIS) database is an invaluable tool

> We want to ensure that the facilities within which we offer care to our service users are appropriate for the 21st Century.

3.3.3 St Pancras Hospital site redevelopment proposals

We are a specialist mental health trust focused on delivering high quality care across a range of services, both within local communities and inpatient settings.

Additionally, we have an acknowledged reputation for world-class academic research, helping shape modern mental health thinking, care and treatment principles.

As such, we want to ensure that the facilities within which we offer care to our service users are appropriate for the 21st century. Many of our buildings though are pre-war and were not designed to support mental health care.

In March 2017, we began an informal engagement process with service users, staff and carers to get their feedback on three options for our sites. These include moving more of our services into the community, building new, up-to-date and welcoming inpatient accommodation in a separate location and bringing all our research onto a single site at St Pancras, to further nurture and strengthen our world-class reputation.

Two of the options would involve selling off part of our St Pancras site to other NHS organisations and also for housing, which would include the development of affordable and key worker accommodation. The proceeds could then be invested in improved community facilities across Camden and Islington, with new inpatient facilities built in either Haringey on the St Ann's site or behind the Whittington Hospital in Highgate.

Meetings with all our stakeholders will continue over the coming weeks and months to glean feedback for inclusion in our Outline Business Case, due for publication in early summer 2017. We will then work towards producing a Full Business Case with the preferred option, based on a range of criteria including stakeholder views and comments. This will coincide with a formal public consultation; however, no building work is likely to start before 2019.

If you wish to be more closely involved in this process or have specific questions, you can email: **communications@candi.nhs.uk** marking your email 'Site redevelopment'.

3.3.4 North Central London Sustainability and Transformation Plan

We have worked closely with our colleagues and partners across clinical commissioning groups, local authorities and NHS providers to develop a Sustainability and Transformation Plan (STP) across the North Central London area (Camden, Islington, Barnet, Enfield and Haringey).

The basis of the STP is that for the NHS to meet the needs of future patients in a sustainable way, the gaps in health, finance and quality of care between where we are now and where we need to be in 2020/21 need to be closed.

One of the priorities in the STP is mental health, placing an equal weighting on physical and mental health conditions, with the aim of reducing demand on hospital care and inpatient beds.

The STP plans include increasing access to primary care mental health services and improving management of acute mental health problems, building community capacity to enable people to stay well and investing in mental health liaison services.

With our colleagues and partners we worked on an initial STP draft that was submitted to NHS England in October 2016. NHS England subsequently rated the mental health stream as "Outstanding".

The plan, which continues to be developed, was refreshed in February 2017 to reflect further work, including a focus on continuing efficiencies to balance finances.

3.3.5 Our new Clinical Strategy

Our five-year Clinical Strategy was unveiled just before the 2016/17 financial year and has now been setting the course for the transformation of mental healthcare in our boroughs for more than a year.

Developed by service users, carers and staff, the vision aims is to support service users so that they can return to living fulfilled lives in their communities.

We want to ensure that people are treated in a way that jointly takes account of their physical and social needs, alongside their mental health requirements.

The strategy is built on ten separate guiding principles.

A key plank of it is the development of practice-based mental health teams in the majority of GP surgeries and elsewhere in primary care.

Evidence shows that these are better-placed to engage effectively with those who do not require hospital-based mental health services and to support GPs caring for people with chronic but stable mental illness.

This approach is already enabling the Trust's senior clinicians to speed up diagnosis and referral to the right specialism.

The Trust's emphasis on GP practice-based mental health care is reflected in its particular approach to caring for people with psychosis.

Working in partnership with our clinical commissioners and local authorities, C&I is developing a network of services, a so-called Integrated Practice Unit (IPU), which is able to provide mental and physical healthcare for individuals with a diagnosis of psychosis.

Helping Ayo's and other service users' physical health needs alongside supporting their mental healthcare

The ten overarching themes and principles of our new clinical model and examples of key progress during the year – ahead of more detailed updates in the Performance Section – are:

- **We will co-produce with our service users and carers their treatment and support**

  Progress: throughout 2016/17 we facilitated an "Evolution" process through monthly workshops involving staff and service users. These workshops addressed all the main elements of the Clinical Strategy and also created the Trust's new Service User Involvement Strategy.

- **We will work in a recovery-orientated way**

  Progress: during autumn 2016, the Trust developed new strategic priorities. One of the three agreed priorities, "Helping people to live well", addresses the area of recovery and wellbeing, whilst acknowledging that a full 'recovery' may not be possible for every individual.

  During the year, the Trust also developed a recovery strategy to improve or establish recovery-orientated practice throughout the Trust. Amongst recommended actions were: developing the Recovery College and more effective use of Peer Support workers.

- **We will offer evidence-based interventions**

  Progress: through the performance framework we continue to work towards fully National Institute for Health and Care Excellence (NICE)-compliant services.

- **We will choose outcomes (desired end results) that measure things that matter to service users and carers and use these to shape our services**

  Progress: Our five-year project to closely integrate physical health and mental health care for our service users with severe mental health issues - our Integrated Practice Unit for Psychosis - had a first year of great energy and commitment from Trust staff and service users. We are now reporting progress in many of the 18 outcomes, either through the Patient Reported Outcome Measures (PROMs) process, or through clinical reporting from a Trust-wide Physical Health Screening Tool.

- **We will integrate with other services so that service users have their mental, physical and social needs met in a coherent way**

  Progress: Practice-based care (Primary Care Mental Health) was successfully rolled out with positive feedback in Islington and Kingston. Our new Integrated Practice Unit has successfully raised the profile of physical health long-term conditions in our psychosis services. We will review the role of social work and social care and report back in 2017/18.

- **We will prevent mental illness deteriorating or relapsing in all our service users and we will contribute to initiatives that prevent mental health problems in children and young people**

  Progress: We are providing, for example, clinical psychological expertise in a multi-agency, mental health-led project, aimed at tackling gang culture in Camden. It is focused on reducing serious youth violence and offending, by encouraging young people to undertake training and education, and promote emotional wellbeing and positive mental health.

- **We will equip all our clinical staff to address drug and alcohol problems**

  Progress: We have successfully developed a screening assessment tool for drugs and alcohol and are measuring uptake in mental health teams via a Commissioning for Quality and Innovation(CQUIN) target.

- **We will improve access to our services for everyone, regardless of gender, race, ethnicity, disability, sexual orientation and other protected characteristics**

  Progress: Control measures are in place to ensure that we comply with all the organisation's obligations under equality, diversity and human rights legislation. During the year we also launched a new Black Minority Ethnic (BME) staff network - Network for Change - to ensure a fully fair and representative workforce.

- **We will choose a quality improvement methodology and implement it**

  Progress: The Trust has now adopted a Quality Improvement (QI) methodology and around 200 individuals have signed up for the Institute of Mental Health online training courses. These courses equip staff with the skills to make small or big changes in their area, effectively and quickly and allows us to measure the results in a meaningful way.

- **We will grow our already strong interest in research**

  Progress: We have again become the top recruiting mental health Trust across North Thames for study participants, with 1,507 service users recruited to our research studies compared with 1,097 the previous year. Our academics continue to attract a level of grant funding and in 2016/17 drew additional research capability funding (RCF) of around £700,000.

In section 3.4 each of the Divisions will report in greater detail on their achievements and challenges in the year 2016/17.

3.3.6 Our principal corporate objectives and risks for 2016/17

The Trust's high level corporate objectives were refreshed by the Board of Directors in February 2017. The Board of Directors will remain focused on delivering the Trust's new strategic aims and activities which support the development of the STP.

C&I's six high level principal corporate objectives

C&I High Level Principal Corporate Objectives	
1	We will deliver safe, high quality, compassionate care for our service users and promote equality and diversity within the resources we have available.
2	We will make measurable progress towards implementing our new Clinical Strategy, improve the integration of physical and mental health services and expand the practice-based service.
3	We will develop, value, empower and retain a diverse workforce with the right skills and behaviours to support the Trust's strategic objectives.
4	We will achieve our control total and deliver an agreed surplus as part of our two year financial plan and ensure that our plans are underpinned by affordable and sustainable service delivery and investment.
5	We will take forward the development of the St Pancras site (and related community sites) Business Case, in order to deliver improved mental health services for the population, and in support of the overall objectives of the wider NHS and local community.
6	We will work as part of NCL STP to design and implement new care models.

The Board of Directors considered the key issues and risks that could potentially affect the Trust in delivering its principal objectives. These risks form part of the Trust Board Assurance Framework and are monitored by the Board on a quarterly basis. The key risks are associated with safer staffing requirements and workforce; sustainability and transformation as part of the North Central London STP; and risks associated with the Trust's estate plans.

3.4 Our services and how they have performed

Our services are organised into five divisions.

These are:

- **Community Mental Health;**
- **Recovery and Rehabilitation;**
- **Services for Ageing and Mental Health;**
- **Acute;**
- **Substance Misuse Service.**

Most of our services provide care for people in their own communities, and work with people towards their own recovery.

3.4.1 Community Mental Health

The community mental health division provides a range of services to meet the needs of the populations of Camden, Islington and Kingston-upon-Thames. We offer services across the care pathway spanning primary, secondary and tertiary care assessment, treatment and management. We also provide mental health services for Veterans - ex-servicemen - from all across London.

Primary Care

Our primary care services include our iCope services which are designed to improve access to psychological therapy for people with common mental health problems.

These teams consistently receive high levels of referrals. (See later in this section for more detail on our iCope teams).

Our development of practice-based mental health teams is another innovative, highly effective model of care. These teams consist of specialist multi-disciplinary teams of psychologists, pharmacists and mental health nurses, led by consultant psychiatrists who work alongside GPs to provide specialist mental health assessment, consultation and short term interventions in non-stigmatising settings close to the service user's home. The model has been co-produced with service users.

Our Islington practice-based teams receive very positive feedback from service users and GPs. Due to their presence, 30% fewer patients go on to need specialist secondary care mental health services than those practices that are unable to access the service. Practice-based mental health teams offer a service to nine of the 34 GP practices in Islington and will expand across the whole of the borough in 2017/2018.

In Kingston, our practice-based team has successfully managed more than 90% of all patients referred within primary care. In the past, 100% of patients would have been referred into secondary care services.

The division is delighted that this year saw the creation of the Practice-Based Advisory Committee (PBAC), a service user group which advises the Trust on key issues and concerns of service users of practice-based mental health services. It provides feedback on proposals, initiatives, ideas, plans, and communications related to practice-based mental health care. PBAC is supported by the 'Side-by-Side' network which offers expertise and guidance.

2016/2017 saw the launch of our new primary care-based employment support intervention. We are working with Islington Clinical Commissioning Group, Islington Council and NHS England to test the effectiveness of the Individual Placement and Support (IPS) model to help people who are out of work due to a health condition and/or disability to return to employment if they wish to do so. There is already strong evidence that IPS has a positive impact on employment for people with severe and enduring mental illness. This trial tests IPS principles in a primary and community care setting and the new team received 115 referrals in its first three months.

Specialist Care Pathways

Our specialist care pathways offer clearly-defined, NICE-compliant treatment and support. These services provide specialist assessments and management beyond what is possible in primary care. They sit within a range of community services including:

- The Complex Depression Anxiety and Trauma service (CDAT) which provides multi-disciplinary, holistic, ongoing assessment of need, multiple-problem formulation, psychological treatment at different levels of intensity and case management for people suffering with complex presentations of depression, anxiety and trauma;
- Personality Disorder Service which provides structured clinical management, care coordination and a range of specialist evidence-based therapies to those service users with personality difficulties who require intensive, specialist input. In addition, the Psychologically Informed Consultation and Training service works to equip the wider system with knowledge and skills in the effective management of personality disorder;
- Psychotherapy services in both Camden and Islington for people seeking to explore the underlying causes of their emotional difficulties;
- Traumatic Stress Clinic (TSC) and the London Veterans' Service which works closely with those who have experienced trauma; and
- Neuro-Developmental Disorders Service for people with Attention Deficit and Hyperactivity Disorder and Autism Spectrum Disorders.

We also provide innovative services to improve access to specialist mental health support for difficult-to-reach groups and for those with physical health and long-term conditions. These include the Gangs Project (see further detail in the Accountability Report on page 42), a Parental Mental Health Service and Transitions Services for adolescents moving into adult services.

Despite significant demand across all Community services in 2016/17 we achieved the following:

- Won the contract to provide a Veterans' Mental Health Service to London and the South East, a service we will deliver in partnership with local organisations across London and the South East/Sussex (see later detail in the Performance section on this service)
- Commenced Transcranial Magnetic Stimulation, an innovative treatment for drug-resistant depression
- Delivered new specialist group treatment (STEPPS) in our personality disorder services.

Steve receives support from the London Veterans' Service

Camden iCope, Islington iCope, Kingston Wellbeing Service

C&I runs three Improving Access to Psychological Therapies (IAPT) services: Camden iCope, Islington iCope, and Kingston iCope.

The services provide evidence-based psychological interventions for people with the full range of common mental health problems including depression and anxiety. They provide and promote a stepped care approach in line with the NICE guidelines, offering patients the most effective, least intensive intervention first. A range of interventions are offered by the services including Guided Self-Help, psycho-educational workshops, Cognitive Behavioural Therapy, Counselling for Depression, Interpersonal Therapy, Dynamic Interpersonal Therapy, Behavioural Couples Therapy and Mindfulness.

During 2016/17 the total number of referrals was over 22,800, with the number of self-referrals growing steadily in Camden and Islington. When people refer themselves, they are more likely to engage in and benefit from treatment and reflect the ethnic mix of the community.

A national target for IAPT services is that 15% of the local population with anxiety and depression should be offered treatment each year. All three of our services met and exceeded this target this year. Islington iCope, in particular, has had consistently high access rates with an end year position of 17.2%. Our performance positions us well to deliver on new, higher national access targets set for 2017/18.

Over the last year, live data shows that 50% of people receiving IAPT treatment in Kingston 'recovered', 49% in Islington, and 49% in Camden, with these figures based on self-report measures of anxiety and depression. In Camden and Islington, considerable work has been undertaken within teams to continue to improve recovery rates and a description of this work has been published by NHS England as a Good Practice Case Study.

Below, are a few recent quotes from people who have used the service:

'Having never engaged with any mental health therapy I found this very helpful. It has given me steps to better wellbeing and shown me that I can overcome most things.'

'A fantastic experience - I learnt a great deal and I know I will be using my new skills in the future. I felt my therapist was warm, friendly and extremely caring.'

Waiting times to enter treatment have been kept within the target of 42 days for the majority of people using C&I IAPT services and the services are reliably meeting NHS Improvement waiting time targets. In the last six months, Camden and Islington reported well over 80% of people entering treatment within the six-week target and this was over 90% in Kingston.

Within Camden and Islington, iCope service users have been actively involved in shaping developments through participation in Advisory Groups, Interview Panels and psycho-educational groups. Recently, we recruited four paid Peer Wellbeing Workers who will help deliver our group and workshop programme.

The services all offer out-of-hours appointments and we have also worked closely with other local organisations to make sure our services are taken up by people from the Black, Asian, and Minority Ethnic communities. In Camden, we have done a lot of work with the Bangladeshi community, together with local partner organisations, and a summary of this work was recently published by NHS England as one of the Good Practice Guides for IAPT services.

Camden and Islington iCope services have continued to work closely with employment support services this year. We have a range of employment workers embedded in our teams, iCope staff have provided training for staff at local job centres to increase awareness of mental health issues and the treatment available, and we continue to run clinics in local job centres. This work will be further developed this year, as both Kingston and Camden have been successful in obtaining additional national funding to have more employment support workers working closely with IAPT teams – as part of the national IAPT employment initiative.

iCope has further developed its work with people who have long term physical health conditions (LTCs) this year and the number of people with LTCs who access our services has continued to increase. Islington iCope has recently been part of a winning bid to be one of the new 'Integrated IAPT' services that also offers care for diabetes and chronic obstructive pulmonary disease, together with Haringey IAPT. In Camden, specialist workers within the service have provided staff training and consultation to support work with people who have LTCs. iCope staff have offered sessions as part of LTC pathways, contributed to self-management groups and have provided training for LTC staff. In the last year, we have developed a series of groups for people with hypertension run jointly in primary care with a specialist hypertension nurse.

All three of our IAPT services have expanded their use of digital options in the last year. Kingston iCope has been using a programme called Mind District to offer computerised Cognitive Behavioural Therapy (CBT) which it will use to deliver interventions to the local Korean population. Camden and Islington iCope have been using a programme called Silver Cloud to provide an online option for people wanting guided self-help. This year, we will also be offering an online insomnia treatment programme, called Sleepio, in all our services. We are piloting the use of Skype therapy for those who struggle to attend appointments.

London Veterans' Service (LVS), now Veterans' Mental Health TIL (Transition, Intervention and Liaison) Service – London and South East

In partnership with South London and Maudsley NHS Foundation Trust (SLaM), C&I runs a free NHS mental health service available to all ex-serving members of the UK Armed Forces, living in London and, Greater London.

It provides a comprehensive multi-disciplinary assessment of mental health needs and related difficulties with support or treatment that can help individuals get their life back on track.

Such recommendations may involve help from a local NHS service or from other organisations, such as Combat Stress or other charities.

In the course of the year, the profile of the service was raised in a promotional campaign to break down barriers and stigma to access, with strong involvement of service users and the support of the Trust's Communications Team.

Service users helped promote the services through production of short films of their own stories of mental health issues, and social media activity

Health Secretary Jeremy Hunt and Sir Keir Starmer, Holborn and St Pancras MP, were among high-profile visitors invited to learn more about the work of the service.

LVS launch - Nurse, Angela Smith, provides her perspective at the Prison In-reach expansion

In October 2016, C&I Chair Leisha Fullick launched the extension of the LVS HMP Wandsworth Prison In-reach project to three further prisons: HMP Brixton, HMP Thameside and HMP YOI ISIS, funded by the Covenant fund. The focus of this work is helping ex-service staff cope with all mental health difficulties, including traumatic stress, while serving in the armed forces, to acclimatise successfully following release from prison.

Key note speakers included Jon Bashford, the author of the Gate to Gate report (2016) and Richard Swarbrick, Veterans Health Lead, NHS England.

Referrals to this service are primarily generated from prisoners identified through the prison reception screening process. All referrals are assessed by Clinical Nurse Specialists based within each prison and a care plan is developed with the veteran, with care facilitated "through the gate" on leaving prison. This includes offering all prisoners an appointment at the service at St Pancras.

A core task of the clinical nurse specialist is to help veterans access mental health, social and welfare services in order to reduce the risk of reoffending and ensure communication between statutory and third sector organisations.

From November 2016, the service was commissioned by NHS England to provide a Veterans' mental health service across London and the South East for service personnel in transition.

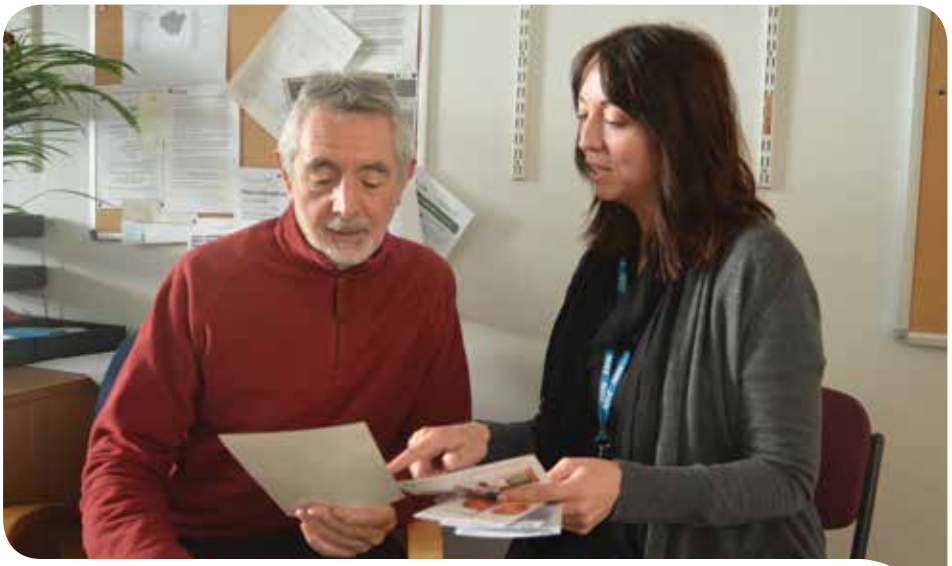
The service has been awarded funding from the national charity, Queen's Nursing Institute Fund for Innovation and Leadership 2017, to deliver a 'Light bulb' course, providing a new format for psycho-education and skills training in order to help veterans to better understand and manage common symptoms of post-traumatic stress disorder (PTSD).

These include hypervigilance, nightmares, flashbacks, sleep disturbance, anger and irritability, and alterations in mood and cognitions.

The service was also awarded the London and the South East contract to deliver a veterans' mental health service to the whole of the London and South East. We have partnered with Sussex Partnership Foundation Trust to cover this geographical region.

This service is one of four regional services NHS England has re-branded as the NHS Transition, Intervention and Liaison (TIL) Veterans' Mental Health Services across England. This service went live on 1 April 2017. The LVS will be changing its name to the Transition, Intervention and Liaison (TIL) Veterans' Mental Health Service London and South East.

The London Veterans' Service has helped many ex-servicemen such as Neil



3.4.2 Recovery and Rehabilitation

The Rehabilitation and Recovery Division works with around 3,600 people with a diagnosis of psychosis across Camden and Islington, providing over 80,000 appointments or other forms of contact in a variety of clinical settings including:

Inpatient and community rehabilitation wards and projects; Early Intervention Services, provided in partnership with Child and Adolescent Mental Health Services (CAMHS) which support people with a suspected First Episode Psychosis; locality-based community rehabilitation and recovery teams and assertive outreach teams for clients with complex needs and a history of poor engagement. We also provide day care services, intensive support teams and liaison with partners in the non-statutory, supported housing sector and other non-statutory organisations.

Our goal is to support recovery from psychosis and to develop a collaborative therapeutic partnership with service users which supports autonomy, hope, dignity, respect and compassion.

Over the last year the division has implemented a five-year initiative to integrate physical and mental health care in those with psychosis, working in collaboration with GPs and acute trusts. This has involved working with colleagues in the Trust's Acute services and Services for Ageing and Mental Health, as part of an approach that addresses the population as a whole. The specific aim of the Integrated Practice Unit (IPU) for Psychosis is to reduce the mortality rate of those with a serious mental illness. The work is being carried out through the implementation of wellbeing clinics within Camden and Islington.

Through the development of joint working protocols with acute trusts and mental health professionals, referral pathways have been improved for those service users with identified long term conditions such as diabetes, cardiovascular disease and chronic obstructive pulmonary disease (COPD). After its first 12 months, the Trust is on track to:

- Reduce the suicide rate among psychosis patients by 20% by 2022
- Cut the percentage of smokers in this group by 2% by 2020
- Widespread screening for diabetes in these individuals to stabilise levels to 18% or lower by 2022

In its first year in operation, a total of 10% of service users across Camden and Islington, who have psychosis and who are involved in the initiative, no longer smoke thanks to specialist support.

C&I rehabilitation services host Ireland health team at Highgate Mental Health Centre

The Trust is now expanding its programme to tackle other physical health problems in this group, such as diabetes and COPD alongside reducing suicide levels. In addition, five physical health and wellbeing clinics had been opened, run by the division. Staff have also been issued with Physical Health Skills Passports, for monitoring and logging additional physical health assessment training. A specially-designed Physical Health Screening Tool has led to assessments and further help or treatment for more than 120 service users.

As one of the Trust's three priorities is Research and Innovation, relevant opportunities have been consistently sought to develop and implement interventions based on research evidence. An example is the work being undertaken by Dr Elvira Bramon, C&I Consultant Psychiatrist and Head of the Mental Health Neuroscience Research Department at the UCL Division of Psychiatry, who with fellow researchers has been focusing on the biological markers for psychosis and their genetic influences.

The Recovery College

The Recovery College, located at C&I's St Pancras Hospital site, offers free, aspirational courses on recovery and wellbeing and is open to everyone in the community – service users, family, friends and members of the public.

It works on a model of co-production, with courses created and delivered by two tutors working together. All courses are interactive and positive learning experiences, emphasising hope, control and opportunity.

During the year we more than doubled the numbers of students enrolled with the College to 1,245 overall.

In its second year since opening, the College delivered a total of 212 sessions to its students, with many more taster sessions and visits to different organisations to introduce its work and raise awareness of its portfolio of 33 educational courses.

The College also secured extra funding through the Islington Community Education Provider Network to train more peer educators, develop new mental health courses in workshops and enable them to be delivered in health and social care settings.

All courses are unique and built from scratch, informed by research of the two College tutors and incorporating theory from different social sciences, medical literature and clinical literature, and structured around interactive and experiential lessons. There is a strong focus on co-production and involving the students on our courses to determine their views on course structure and aims.

The College attracts a good mixture of students from across our boroughs, although Trust staff are currently under-represented. It is expected that even more recovery-focused practitioners will emerge and develop during the year.

The Recovery College offers free aspirational courses on recovery and wellbeing

Tom helps care for chicks, encouraging more social interactivity and engagement

Professional tutors from the Trust are contributing immensely to the College, which is building on their strengths and offering them an alternative perspective and more flexibility away from a clinical setting.

An important transition has been made within the team and supplier tutors have now been integrated as staff, providing them with more support via supervisions, wellbeing plans and to support access to Occupational Health. This also gives them flexibility to book variable hours, helping those for instance who are returning to work.

Further data collected by the Trust's quality performance team over three terms revealed that on average 67% of students were Trust service users, of whom 42% were part of the Care Programme Approach, 20% had been discharged from secondary care and 33% had psychosis-related conditions.

In a further development, the Recovery College elected its first Recovery Board, following its Annual General Meeting. The Board represents people with lived experience and staff who have experience of working in mental health care. In its second year of offering courses, the College provided 33 co-produced courses and delivered 214 course sessions with 614 students enrolled.

3.4.3 Services for Ageing and Mental Health

Services for Ageing and Mental Health (SAMH) provides high quality, NICE-compliant, specialist assessment and care for people living with dementia and those suffering from mental illnesses associated with ageing.

Our service users often experience a range of physical health problems and are reliant on support from carers and other parts of the NHS and Adult Social Care. The best outcomes for our service users have been achieved by SAMH working more closely with both Primary Care and Adult Social Care in Camden and Islington, whilst continuing to recognise the central role that carers have in supporting our service users to remain in the community.

During 2016/17 SAMH teams received 3,024 referrals, the majority of which were new to the service, and discharged 2,395 service users. Our staff worked with approximately 3,000 older people in Camden and Islington throughout the year, 80% of whom will have a diagnosis of dementia, or are being assessed for this condition. The level of involvement that we have with our service users is broad, ranging from an annual review through to 24 hour inpatient care.

> For people with dementia, we are now able to provide both assessment and diagnosis, and, where appropriate, ongoing clinical support through our memory and dementia navigator services.

For people living with dementia in both boroughs, we are now able to provide both assessment and diagnosis, and, where appropriate, ongoing clinical support through our memory and dementia navigator services. We anticipate an increase in patients receiving ongoing support from these services as more people receive an early diagnosis.

SAMH supports older people with mental illness and those with dementia, who have the most complex needs, through our two Community Mental Health Teams, which work with approximately 450 older people across Camden and Islington, providing an integrated mental health and social care service.

Over the last year, we have continued to enhance our acute care pathway and more patients have received care from both our Home Treatment Team and our Community Recovery Service. These services are designed to provide more intensive support for people at risk of hospital admission, or who require support to be discharged earlier. During 2016/17, we were successful in admitting fewer patients to hospital directly from their own homes. However, the number of patients being admitted to older people's mental health beds directly from acute hospitals remains a concern for the division. Therefore, during 2017/18, our Home Treatment Team will be enhanced to try to provide better discharge support for this group of patients.

Learning Disabilities

C&I continued its successful partnership with Camden and Islington councils to provide integrated services for people with Learning Disabilities who have a mental illness, with 24 of our clinical staff working in these joint teams.The Care Quality Commission rated our Learning Disabilities services in 2016 as good in all aspects of care, commenting that:"Patients and carers had a positive experience of care, staff treated patients with care, compassion and communicated well."

During 2016/17 both learning disabilities services have been focused on the "transforming care agenda" with its two key themes: taking action to bring people with severe learning disabilities home from out of long term hospital care, and using At Risk of Admission registers/urgent multi-agency planning processes to avoiding psychiatric hospital admission for this group whenever possible.

3.4.4 Acute services

Our Acute Division provides urgent assessments and care to service users experiencing an episode of severe illness and who require an intensive period of treatment. An average of 1,315 individuals are treated each month across the system in inpatient services and acute community crisis services such as Crisis Response teams, Crisis Houses, A&E Liaison teams and Acute Day Units.

We continue our commitment to improving our care planning process to ensure that all service users are actively involved in planning their own care. We have a well-established operational model across all acute division teams which is based on daily multi-disciplinary team care planning discussions and early review of all new service users by a consultant.

Emerald Ward - a new 16 bed acute ward - opened in April 2016. This resulted in a significant reduction (from 190 in 2015/16 to 56 in 2016/7) in the use of out-of-area acute beds.

In 2016/2017, we embedded the Discharge Policy and the revised Bed Management policy in practice. There was particular emphasis on the role of the Crisis Team in the Gatekeeping process for inpatient wards; and on the roles and responsibilities around the bed management process – especially for those waiting for an inpatient bed.

In February 2017, the first of a series of workshops took place in the Acute Division - entitled "Thresholds for Inpatient Care" - in order to support clinicians to consider improved ways to ensure that service users who require an inpatient bed will be admitted in a timely manner.

New escalation processes were developed with our three partner A&E departments; and the Acute Division began to trial participation in the Single Health Resilience Early Warning Database (SHREWD) capacity tool for North Central London. In 2017, the Crisis Team Call Centre began to trial effective, seamless transfer to specialist mental health care for service users who call the NHS111 service without them having to re-dial another number – known as "warm transfer".

In September 2016, the Acute Crisis Services held a successful three-day "Hothouse" event to consider future models for urgent response within a new four- hour target and for handling the ever-increasing volume of calls to the Crisis Team Call Centre. A revised model of Crisis Care was presented to both sets of commissioners in December 2016 and piloted in the Islington Crisis Team in February 2017.

There was a particular focus on Quality Improvement in 2016/2017 and each team was supported to deliver a "Team Building / Strategy" day. The division continued to absorb feedback from service users and others and saw an improvement in the completion and in the rating with regard to "Friends & Family" tests.

The division drove the efforts to improve the quality of the Health-Based Places of Safety in the three A&E departments. Alongside our colleagues in the acute provider Trusts, significant improvements have been made with regard to the safety of those environments as well as improving the quality of privacy and dignity for those who are detained under Section 136. In February 2016, the Acute division led a Camden and Islington-wide workshop to discuss how we will work towards achieving the standards for the Section 136 pathway, as set out in the Healthy London Partnership guidance 2016.

In late 2016/2017, we further enhanced the "Trauma at Work Pathway" by introducing a "Recovery Day" opportunity for those staff affected by trauma at work.

The Acute Division continued to invest in our recruitment and retention strategy and saw a significant decrease in turnover and vacancy rates as a result.

We embedded the HealthRoster system across all teams in the Acute Division and saw a reduction in the use of Agency and NHSP staff. There is a continued commitment to the SafeStaffing agenda and the Acute Division now routinely uses the SafeCare tool to report variations in acuity of inpatient wards.

3.4.5 Substance Misuse Service

Our Substance Misuse Service provides high quality, NICE-compliant, and specialist community services to around 2,000 people with drug and alcohol problems across Camden, Islington and Kingston-Upon-Thames. Working to a recovery model, we have seen an improvement in people remaining abstinent.

Since 1 April 2016, we have been delivering a new drug service in Camden in partnership with WDP (Westminster Drug Project), the Camden Specialist Drug Services, which is for clients with complex needs, in addition to their substance misuse problems. Since launch, the service has developed an exciting new Group Programme that addresses the recovery needs and ambitions of our service users. Our club drug clinic, GRIP, has continued to grow and we have been involved in a number of local training events.

During the re-commissioning of drugs services which took place in 2015/16, a non-complex needs drugs service was set up by CGL (Change Grow Live, formerly CRI – the Crime Reduction Initiative) and around 200 of our service users had their care and treatment transferred to this new service which has sites in Camden, in Royal College Street and Kilburn High Road.

In the Integrated Camden Alcohol Service, (ICAS based at Early Mews, Camden), we also work in close partnership with CGL and have developed an innovative Alcohol Assertive Outreach Team for frequent alcohol-related attenders at the local acute hospitals. A recent audit of this new team's activity showed marked decreases in A&E attendance for a number of individuals.

In Islington, we continue to provide treatment via the complex needs service across two hubs (Islington Drug and Alcohol Specialist Service - IDASS - North and South) and via in-reach into CGL Islington's low threshold prescribing service. We have also expanded our work with mental health teams in the borough providing consultation and some individual supervision to the Early Intervention Service, Recovery and Rehabilitation Division and Assertive Outreach teams.

In April 2016, commissioners in Kingston extended our contract for the Wellbeing Service and made us overall lead provider for Substance Misuse Services in the borough, with our overall contract being extended to March 2019.

The Substance Misuse Service part of Kingston Wellbeing Service (KWS) is currently undergoing a service redesign to adopt a one team approach, rather than three separate teams working with different specialties. The aim of this is to give the service user a treatment experience which is seamless, with all staff being able to offer the same skilled support from beginning to end.

There is a strong group of Peer Mentors, who have experienced the treatment offered at KWS and have progressed to offering support and inspiration to current service users. Part of this is a community group run by Peer Mentors supervised by staff, offering a hot meal and a safe place for one afternoon per week. This facility has the full backing of the commissioners who are keen to support the sustainability of this group. This group is supported by us and WDP.

Several satellites have been set up in the borough, including fortnightly drop-in services at Kingston University, the Job Centre Plus and the local Sexual Health Clinic.

A successful pilot project to engage the high numbers of street drinkers in Kingston has been recommissioned.

Our division has also taken a lead role in developing an online training package to enable all clinical staff across the Trust to be able to carry out a basic assessment of substance misuse on all service users.

3.4.6 Business development

Bids and Tenders

Since September, the business development team has taken more than 40 tender opportunities to divisional leaders for their consideration. Of those taken forward, C&I maintained its Camden IAPT service, after the external procurement did not go ahead; extended Substance Misuse Services in Camden; secured NHS-England funding for a veterans' mental health transitions service across London and secured a contract to extend the London Veterans' Service until 2020, as part of a new service where C&I also sub-contracts services in Sussex, Kent and Surrey to NHS partners.

Divisional Liaison

Each C&I division is now supported by an individual Business Development Manager (BDM), who agrees priority projects, researchs the market, monitors upcoming tenders and contract ends, engages internal and external partners for joint projects and ensures no opportunities for growth are missed. This new way of working has improved business development's visibility in the organisation and has been welcomed in every division.

C&I Wellbeing

This is a new service that will offer one-to-one therapy and workshops to businesses in the commercial sector with the aim of improving employees' mental health and wellbeing. C&I Wellbeing will build on C&I's reputation as a good quality NHS provider. Development of this service is still ongoing but the recruitment from our pool of Trust psychologists, workshop development and development of relationships with potential customers through new and existing networks have all begun.

The Trust's new simulation suite at St Pancras

3.4.7 Simulation Suite

During the year, we became one of the first mental health trusts in England to open a simulation suite to support clinical staff in developing their skills in communicating with patients, including in sensitive situations.

The suite, at the Trust's main St Pancras site, is available for trainee psychiatrists and other clinical staff including psychologists, mental health nurses and social workers.

3.5 Performance analysis

This Performance Analysis summarises Trust performance for 2016/17 and includes information, below, about how we measure our performance against national requirements. A full and detailed analysis of all aspects of our performance can be found later in this document in the Accountability Report, Quality Report and the Summary Financial Statements.

We check the quality of the data we use to measure performance through our Information Assurance Framework. This provides a current update on the data quality and data improvement plan for all the 2016/17 Key Performance Indicators, which were agreed with colleagues from Camden and Islington Clinical Commissioning Groups and the Commissioning Support Unit.

We monitor any current or future risks to our performance through the Trust's risk register and present a Performance Report on a quarterly basis to the Board.

3.5.1 Performance framework

We also report on a monthly basis to the Board on the performance of the Trust's five divisions: Acute, Rehabilitation and Recovery, Community Mental Health, Services for Ageing and Mental Health, and Substance Misuse Services. At these monthly divisional performance meetings each division is RAG (Red, Amber, and Green) rated across four domains: quality, workforce, performance and finance.

3.5.2 Internal high-level performance indicators

We use four high-level indicators to measure performance internally, namely: safety, service user experience, organisational effectiveness, and delivery and quality.

During the year, we have focused hard after negotiation with our commissioners on a broad range of quality activities under the CQUIN scheme to improve the quality of care and the experience of staff and service users.

The Trust achieved 80% of its CQUIN goals, which was worth £1.625m. This was 2% of the total contract from local commissioners and covered the areas of staff health and wellbeing, mental health, substance misuse, physical health, prevention of domestic violence and quality of crisis planning.

The CQUIN results for 2016/17, show good progress in some areas, including staff health and wellbeing initiatives, improving physical healthcare to reduce mortality in those with SMI (Serious Mental Illness), quality of crisis planning and staff training to prevent domestic violence.

There was also progress to improve smoking cessation care planning and treatment. However, CQUINs covering provision of more detailed information for prescriptions such as reasons for prescribing, dose, and side-effects, and obesity prevention and management in hospital were not met. The Friends and Family Test (FFT) asks service users whether they would recommend the Trust to their family or friends and is an important measure of patient satisfaction.

At the end of March 2017, the Trust's monthly response rate was at an all-time high and Trust-wide during the year 2,472 responses were received compared with 1,324 the year before – an increase of 87%.

> In common with other Trusts, both in London and other parts of the country, C&I continues to experience significant pressures on the available bed base.

Just over 92% of all FFT responses in March 2017 indicated service users would recommend the Trust to others if they needed similar care or treatment.

This has been reflected over the year with the monthly proportion of responses recommending the Trust consistently above the 80% target. The Trust has succeeded in reaching its target of ensuring that every eligible team has at least one FFT response recorded during the year.

There was a decrease in incidents reported, with 5,923 in 2016/17, a drop of 10% on the previous year.

This may partly reflect a decrease in incident reporting, which the Trust is further examining and will address if necessary. However, there were decreases in some categories that also indicated effective improvement action.

The most evident was in the falls category representing about half of the overall decrease reflecting changes to falls reporting, as well as improved falls management through the Fall STOP project. There was also a decrease in the reported number of incidents in the Missing from Care and AWOL category – a fifth of the overall decrease – partly due to a focus on this area by the AWOL Task and Finish Group.

There were also significant decreases in reported incidents of people smoking illegally on Trust premises and of IT Clinical Safety incidents, the majority of which related to fewer incidents of access issues with CareNotes compared with the previous year when the Trust made the transition from RiO to CareNotes.

In common with other Trusts, both in London and other parts of the country, C&I continues to experience significant pressures on the available bed base. The Trust's policy is absolutely clear that when someone needs an inpatient admission they will get one. This sometimes means that when bed occupancy is high (>95%) people need to be moved between beds for non-clinical reasons so that those in greatest need have the most appropriate bed.

Our focus in 2016/17 has been continuing to ensure that when these moves happen, they happen safely and effectively with comprehensive handovers.

During the year, reflecting a range of measures including additional community responses, we achieved several months of managing demand within our own bed base.

In March this year, however, demand for Trust beds was put under considerable pressure. This was due to a sudden and exceptional increase in the number of individuals within the community needing our support. Additionally, care levels meant discharge levels were lower than average.

To resolve the situation, a series of special measures was undertaken that included:

- Creating a new discharge team incorporating re-ablement and practice development nurses
- Identifying all those in the community that were moving towards needing admission and re-orientating community teams to work specifically with them
- Increasing Trust ward rounds and walk-rounds to facilitate discharge
- Seeking block booking beds locally

3.5.3 NHS national targets

During the year we continued to be assessed on a quarterly basis to meet national standards for access and outcomes. From April 2016, NHS Improvement became the new name for the combined Monitor and NHS Trust Development Authority (TDA) Accountability Framework.

In October 2016, the Single Oversight Framework replaced Monitor's Risk and Assessment Framework, one of the aims being to reduce information burden and to ensure central collection of data.

A series of service performance targets covers seven day follow-up contact and 12 month review of Care Programme Approach (CPA) service users, admissions to inpatient services having access to crisis resolution home treatment teams and people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral.

There are also two Mental Health Data Completeness metrics and three tiers of targets covering recovery rate of Improving Access to Psychological Therapies (IAPT) services in Camden, Islington and Kingston.

For all targets except just one, the thresholds were met. The exception was the proportion of people completing IAPT treatment who move to recovery in Islington, with the 50% target being missed by just 0.7%.

To become and remain a Foundation Trust, it is necessary to demonstrate to NHS Improvement that the Trust is well-led and governed, financially robust, legally-constituted and meets the quality threshold and standards. The Trust has met or surpassed all of these targets and indicators for 2016/17.

3.5.4 Governance and Quality Assurance

The Trust has a number of mechanisms and processes in place to support governance and quality assurance. Oversight of governance and quality is provided by the Trust Quality Committee and the Board.

A new approach by the Advice and Complaints Team to sharing learning from serious incidents and complaints was introduced during 2016/17 and will be further developed and embedded in the forthcoming year. A new Serious Incident and Complaints Learning Bulletin highlights key learning and areas for improvement from reviews into serious incidents and complaints. Learning "newsflashes" are being introduced to alert staff on immediate concerns, and learning from complaints is shared at divisional quality forums. There are regular reports to the Quality Committee and the Board on complaints and incidents.

In addition, a Learning Lessons Workshop has been developed in the Acute Division, with support from the Risk and Patient Safety Manager, to discuss preliminary reviews and final investigation reports into serious incidents and also share learning. It is intended that Service users are invited to attend future workshops and that the other Trust divisions have the opportunity to use this framework.

There is a risk strategy in place and regular review of risk registers. The Trust participates in clinical audit and has introduced Quality Improvement Training to support staff to lead change and improvement in their services.

To further strengthen governance a review is currently being undertaken of the Trust approach to governance and quality assurance. Further detail of the work we have undertaken to improve quality and safety is contained in the Quality Report.

3.5.5 Care Quality Commission inspection

The Care Quality Commission (CQC) inspected the Trust in February 2016 and produced its report in June 2016. While it found many areas of good practice and rated the Trust as "Good" for caring, its overall rating was "Requiring Improvement".

We drew up an immediate action plan to ensure that areas of concern were addressed, many of which were already the subject of attention. To read further detail of the CQC inspection and the Trust's action in response please see section 4.12.6 on page 91.

3.5.6 Equality, Diversity and Human Rights

As a Trust we are committed to improving the experience of our staff, and our service users and to reducing inequalities in health. In 2016/17 we did the following to support this important area of work:

- We re-wrote our Equality & Diversity Policy;
- Rolled out a new Clinical Strategy which includes a focus on Equality and Diversity;
- Published a second assessment against Workforce Race Equality Standard (WRES) which requires workforce ethnicity data to be published on the Trust's website annually;
- Successfully launched our new Black Minority Ethnic (BME) staff network – Network for Change – which aims to:
  - Maintain a safe and positive working environment for BME staff and the elimination of racial discrimination for employees and patients

  - Support the Trust to develop and maintain a representative workforce with inclusive leadership, and to raise the profile of the contribution that BME staff members make
  - Maintain and expand the membership of the BME staff network so BME staff can share experiences relating to their work and professional development
  - Provide a forum and voice to other under-represented or marginalised staff groups
- Established a Task and Finish Group to improve equality data collection systems;
- Successfully applied to join the national NHS Employers Diversity and Inclusion Partners Programme 2016;
- Developed a Staff Engagement Strategy and Service User Strategy to support engagement with staff and service users in order to improve staff and service user experience;
- Signed up to NHS England Learning Disability pledges;
- Successfully implemented the Accessible Information Standard (AIS) to ensure we provide information in alternative formats;
- Communicated our strong and continuing support for our EU staff following the result of the Brexit referendum.

We have identified some key issues with regard to equality and diversity from our annual staff survey and we intend to develop robust divisional action plans in order to address these.

We also hope to report further positive changes following development of the Trust's new retention and recruitment "Our Staff First" strategy which includes a range of initiatives aimed at BME senior recruitment, management and leadership development, and career clinics.

3.5.7 Impact on the environment

Procurement of the Trust's energy supplies has continued through the Cabinet Office's Crown Commercial Service and continued to yield significant financial savings over the past 12 months. We are obtaining best possible tariffs through this method of public sector wholesale purchasing and this will continue into the future.

At St Pancras Hospital, the Trust's HQ and largest site, we have previously installed energy-monitoring equipment for key buildings. Further electrical surveys have given a better picture of energy use across the site and further monitoring equipment is to be installed into key parts of the utility services to maximise savings, analyse cost and check consumption and billing.

The Trust will commission a Sustainable Development Management Plan in 2017/18 to ensure greater focus on environmental impact going forward.

3.5.8 Facilities Management

In 2016, we were scored very highly in a number of areas by assessors from PLACE, the national Patient-Led Assessment of the Care Environment.

The aim of the PLACE assessment is to provide a snapshot of how an organisation is performing against a range of non-clinical criteria and to assess the extent to which the environment supports the delivery of good care.

In the areas of Cleanliness, Food and Hydration, Privacy and Dignity and the Condition, Appearance and Maintenance of the buildings and grounds, we scored above the national NHS average.

Areas for improvement raised in previous PLACE assessments had also been actioned; for example, the segregation of pedestrians and traffic at St Pancras Hospital, the painting of the fence and garden furniture and re-planting of the pots and flower-beds at 154 Camden Road.

During the year, monthly catering surveys were introduced about the food service in a timely manner.

The annual menu review resulted in the removal of less popular items from the menu and the introduction of some more modern dishes requested by service users. The design of the menu folder was also refreshed and enlarged to A4 to make it easier to read.

The West Wing Conference Reception was redecorated in 2016 to make the area brighter and more welcoming.

A number of projects were carried out to enhance the care environment, including the painting of the wards in Ash House and the Huntley Centre at St Pancras Hospital; and the refurbishment of the Occupational Therapy kitchen in Highgate Mental Health Centre.

3.5.9 Our Finances

Although the Trust reported a deficit of £0.1m for 2016/17, it actually delivered a normalised surplus (after impairments of £0.2m) of £0.1m (2015/16: £0.7m). This was a £0.6m decline on 2015/16, and below the planned £0.9m surplus target, before sustainability and transformation funding (STF), set in our 2016/17 financial plan target.

2016/17 has seen an increase in total operating income of about £1.0m from £138.2m. In the same period, expenditure rose by £1.1m and net capital and interest charges grew by £0.6m. This caused the normalised surplus to decline by £0.6m.

The main reasons underlying this are:

- An increase in CCG and NHSE income of £3.6m, predominantly resulting from the application of growth funding for new services, offset by reductions in income from local authorities of £0.9m resulting from reduced funding from London Borough of Camden for section 75 and Substance Misuse Services funding resulting from a tendering process and efficiencies from both local boroughs; and
- A further fall in Other Operating Income which has resulted from reductions in estates recharges, R&D income and salary recharges of £1.6m

The main reasons for the fall in real operating surplus since 2015/16 were that the Trust continued to face significant costs (although reduced materially compared to 2015/16) as a result of placing acute and psychiatric intensive care unit (PICU) patients outside Camden and Islington beds, and budgets were adjusted for cost improvement programmes but expenditure levels did not adjust to the reduced levels.

Pay costs form the most significant element of the Trust's expenditure base, and these increased from £93.4m to £95.6m, while the costs associated with outplaced patients in private sector and psychiatric intensive care units beds fell materially, as the full bed base re-opened following the ward refurbishment programme at Highgate. Of the pay increase of £2.2m, more than half is due to increases in employer superannuation and national insurance.

This continued fall in surplus for the Trust is disappointing and, whilst the Trust's position remains strong compared to many NHS providers, the Trust lost a potential cash incentive of £0.8m from the STF as a result of not achieving its planned surplus.

The regulator of NHS Trusts, NHS Improvement, awards a Continuity of Service rating to Trusts. This is a measure based on the organisation's liquidity, its ability to cover its public dividend capital payments from its earnings, its margin on income and expenditure, the accuracy of its financial planning, and its use of agency staff. The elements of the score relating to margin and to accuracy of planning were newly-introduced in 2015/16 and continued in 2016/17, (with the addition of the agency staff spending target), and, mainly as a result of this, C&I's score remained at the second best rating available (2) rather than scoring a top rating (1).

Historically, a key element of the delivery of the financial result has been the Trust's continuing ability to deliver its cost improvement programme. In 2016/17, a target of £3.2m was set. All of the headroom built into the target was required, but this still failed to ensure overall delivery, and there were clear financial pressures, manifested in overspending on temporary staff in three of our operational divisions and within corporate services.

Partnerships with key commissioners remain effective and strong. For 2017/18, the Trust has planned for a small increase in contract values of around £1.0m. This reflects the very tight financial position faced by our local commissioners, who have little growth money to spend with C&I. Camden CCG has virtually zero growth in 2017/18 and 2018/19, and Islington CCG has growth funding of under 2% annually. This is likely to make the financial position more difficult, as it fails to match growth in the size of our resident population.

> The Trust's balance sheet remained relatively stable during 2016/17 with only minor growth in the assets employed.

C&I's Overseas Visitor (OSV) income collection processes are nationally accredited and we remain a reference site for mental health providers. An effective process that includes formal screening identifies all potential relevant visitors and these are then billed onto our host commissioner.

Whilst the introduction of the mandatory Health Surcharge for foreign students as a visa requirement has removed our ability to recover income for this group, C&I continues to perform strongly in its recovery and remains well in excess of the £2m Risk Share target.

In addition, due to C&I's national reputation on OSV income processes, the host CCG receives 100% of all income the Trust levies via NHS England, offering continued assurance regarding funding the £2m block allocation.

The Trust's balance sheet remained relatively stable during 2016/17 with only minor growth in the assets employed.

The Trust initially had a planned capital programme of £4.7m for 2016/17, and subsequently notified NHSI that it had revised the programme down to £4.2m. At year end, the Trust had spent £4.2m on fixed assets, which was reduced down to £3.8m by successfully negotiating a favourable rebate from HMRC on VAT paid on the 2015/16 capital programme of £0.4m.

In addition to the above capital spend, the Trust also formally declared a property in Hanley Road in North Islington to be surplus to requirements, and has re-classified the property as an Asset Held for Sale, within Current Receivables, with a value of £1.0m.

Due to uncertainties surrounding Brexit, the Trust has deemed it prudent to commission the District Valuer to undertake a revaluation of the Trust's assets, with a valuation date of February 2017. The impact of this exercise led to an impairment hit of £155k on the Trust's I&E and a net upwards revaluation of £449k which impacted on the Revaluation Reserve.

The Trust retained healthy liquidity balances of £44.5m at 31 March 2017. These balances were predominantly held in Government Banking Service accounts, with only minor balances held elsewhere for operational issues. Cash balances were ahead of plan despite the Trust failing to meet its I&E surplus target, primarily due to the receipt of some pre-payments, while recent reductions in base rates have impacted on interest receivable.

Because the Trust has very strong cash balances, it is reasonably confident of its ability to deliver its cost improvement programmes, and expects to at least maintain its income for the next two financial years, whilst still delivering a continuity of service score of at least 2. It has prepared its accounts on a going concern basis.

The Trust faces a number of financial risks and uncertainties:

- Ability to deliver an annual recurring cost improvement plan (CIP) which has increased to nearly £5m per year from 2017/18 onwards. 2016/17's CIP was not fully delivered, and so, for 2017/18 onwards, the Trust has less assurance that the savings can be delivered.
- The regulator of NHS Foundation Trusts, Monitor, requires Trusts to explain their normalised financial position, which is the position when unusual non-recurring financial transactions are removed from it. The Trust posted a deficit for the year of £0.1m in 2016/17, and a normalised surplus of £0.1m. The normalisation adjustments were:

Reconciliation Table

	£M
Deficit for the year (per SOCI)	(**0.088**)
Plus: Impairments	0.155
Normalised surplus for the year	**0.067**

The Trust's Going Concern Disclosure is included in the Other Required Disclosures section of the Annual Report.

3.5.10 NHS Improvement's Single Oversight Framework

Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's Risk Assessment Framework (RAF) was in place. Information for the prior year and first two quarters relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

Segmentation

The Trust is in segment two.

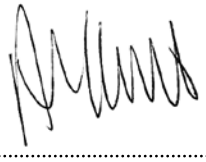
This segmentation information is the Trust's position as at 31 March 2017. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the trust, disclosed above, might not be the same as the overall finance score here.

Area	Metric	2016/17 Q3 Score	2016/17 Q4 Score
Financial Sustainability	Capital Service Capacity	2	2
	Liquidity	1	1
Financial efficiency	I&E Margin	3	2
Financial controls	Distance from financial plan	3	3
	Agency spend	3	3
Overall scoring		**2**	**2**

The Summary Financial Statements are presented at section 6 and form part of this performance analysis.



Angela McNab
Chief Executive
26 May 2017

4 Accountability Report

4.0 Directors' report

The Directors are responsible for preparing the Annual Report and Accounts. The Directors consider the Annual Report and Accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.

For each individual who is a Director at the time that the report is approved: so far as the Director is aware, there is no relevant audit information of which the NHS Foundation Trust's auditor is unaware; and the Director has taken all the steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the NHS Foundation Trust's auditor is aware of that information.

4.1 Working with our stakeholders and service users

4.1.1 Service user involvement in the Trust

During the year we introduced a wide-ranging new plan to give service users greater opportunities and support to be more closely involved in the work of the Trust and in shaping our services to ensure they continually improve and meet the needs of our local communities.

Our new Service User Involvement Strategy 2016-19 was the result of nine months' collaboration between service users from the 16 groups of users of our various services - represented by the Service User Alliance - and our staff. It aims to ensure a consistent approach to encourage and involve service users in the future.

It is built on our 12 years' experience of service user engagement and also addresses calls by service users for even deeper involvement in the Trust and closer co-production of services.

The six key strands of the strategy are:

- Improve access to information so service users are more in charge of their own care
- Ensure staff have the skills and information about local resources to support service users in individual care planning and recovery
- Ensure service users know how to get involved in the Trust's planning and monitoring of services, feeling confident they will be supported. Build stronger collaborative working with the Service User Alliance to ensure active co-creation
- Offer training to service users to develop new skills and access to new roles, alongside recruiting service users with experience of mental health on an equal basis to staff as part of a "peer" workforce
- Ensure service users are recognised, valued and rewarded for their work
- Ensure service users are informed about research activities within the Trust and can participate if they wish.

To support the effective implementation of the strategy, we have created a new role of Service User Involvement Facilitator.

Their role is to help service users have more ownership of their care and to help staff understand the value of service user involvement.

They will work to make sure service users know how to get involved in the Trust and resolve any barriers to getting involved. Additionally, they will ensure service users co-produce a rewards and recognition scheme to reimburse them for their time and input.

Other developments during the year included the appointment of service user representatives to our Mental Health Law, Quality Review and Equality and Diversity committees.

We have held regular conferences for service users at the Trust, providing a platform for the variety of different user experiences to be collectively shared and to ensure development of co-production activity.

Trust staff have taken up opportunities to ensure they are at the forefront of best practice with regard to service user involvement and support including attending external conferences such as a strategic network event.

We have also helped service users widen their experience and knowledge by going to external events, such as attendance by the Nubian Users' Forum at a Black Minority Ethnic "Stop the Stigma" conference in June 2016.

Achievements in the last year include:

- Sharing best practice between service user groups on how to sustain and increase membership, and helping promote them
- Membership of the Patient Participation and Involvement network, a London-wide network which shares ideas for engaging and involving service users
- Committing to co-produce service user conferences at least twice a year
- Updating service user information on the Trust intranet, mapping of all service user groups and their purpose
- Side by Side network successfully established and with diverse membership, to better understand service user needs
- Service users consistently trained and equity in the selection process to be part of interview panels.

4.1.2 Service User Experience

Patient experience ranks alongside patient safety and clinical effectiveness as a key component of quality in healthcare services.

After detailed development work involving many of our staff and service users and formal approval by the Quality Committee, our first Patient Experience Strategy was launched in April 2016.

The four-year strategy was developed with reference to the NICE quality standard for service user experience in adult mental health, the quality priorities set out in the Quality Accounts, learning from serious incident investigations, feedback from Care Quality Commission inspection reports and learning from serious failings in other trusts.

Nubian Users' Forum Open Day

Our Patient Experience Strategy aims to:

- Provide a framework for continuing assessment and improvement of patient experience with clearly defined priority areas
- Ensure the impact of changes on patient experience (positive and negative) of projects, changes and service developments is routinely assessed
- Ensure actions taken to improve patient experience are communicated effectively
- Support the role of the internal Quality Assurance Framework by providing intelligence, oversight and standards for patient experience
- To develop service user-led measures of outcomes for each division, which will be incorporated into the Trust's performance framework

There are five work streams underpinning the strategy: always listening; understanding the things we are told; sharing, collaboration and co-production; responsibility and making changes; and getting the basics right.

During the year there has been limited progress in some areas, due to a number of factors including there being no Patient Experience Lead to co-ordinate and drive implementation of the strategy, the absence of regular oversight of the strategy and lack of recent Quality Assurance Review.

In 2017/18, the focus will be in reinvigorating the strategy and ensuring it remains on track.

4.1.3 Carers

Carers have a vital role to play in our Trust, in supporting our service users and helping them in their care and recovery. During the year, we worked together to ensure we met the requirements of the Care Act, particularly around carers' assessments and safeguarding carers.

A carers' welcome and information pack was also co-produced and introduced.

To further build our good network of staff and carer representation across all clinical divisions, we are adopting the principles of the "Triangle of Care".

This reflects the relationship between service user, staff member and carer and has key elements to ensure effective and professional engagement of the carer.

We are also looking to strengthen the existing Carer Partnership of carers, local carer organisations, commissioners, senior managers and directors, to make it more effective.

This will be part of a co-produced Carers Strategy, developed along similar lines to the Service User Involvement Strategy.

Leading the way in the UK on Transcranial Magnetic Stimulation - (L to R) Charles Hounsell, Dr Mo Abdelghani, Derin Rose, Stephanie Muth

4.2 New and revised services

4.2.1 Transcranial Magnetic Stimulation

In July 2016, C&I became the first NHS Mental Health Trust in London and the south of England to start a Clinical TMS (Transcranial Magnetic Stimulation) service as a new treatment for drug-resistant depression.

TMS devices use a pulsating magnetic field to target specific sites in the brain, stimulating nerve cells in those areas, thereby easing symptoms of depression.

Pioneered by Dr Mark S. George, a Distinguished Professor of Psychiatry at MUSC (Medical University of South Carolina), it became a NICE-recommended treatment for depression in December 2015.

Dr Mohamed Abdelghani, the lead consultant psychiatrist of the Trust's TMS service, became the first British psychiatrist to be formally trained by Professor George.

In January 2017, Dr Abdelghani established the UK Chapter of the clinical TMS Society, whose aim is to increase public awareness of TMS and increasing accessibility of treatment for UK patients.

C&I's TMS service has successfully treated a number of patients and it is now planned to expand the service to offer it to more patients with treatment-resistant depression.

4.2.2 Tile House and Cliff Road

The service provided at these two premises in Camden helps people with highly complex needs receive mental and physical care within their local community, thereby reducing the need for out-of-area placements.

It is an innovative and very successful example of joint working between a clinical and non-clinical provider - C&I and One Housing Group (OHG).

Commissioned by Camden Council, Tile House in the Kings Cross district was opened in 2012 with 15 high quality domestic units, designed to enable risk to be managed appropriately, with fire management, anti-ligature design elements and assistive technology.

Residents receive expert clinical support and their recovery is facilitated more quickly, resulting in an annual estimated savings to the local health and social care economy of £400,000. In June 2016, the service was expanded with provision of a further 12 units at premises in Cliff Road.

The OHG staff are supported by a dedicated C&I clinical team, comprising a psychiatrist, psychologist, occupational therapist and care coordinator.

It is part of a wider strategy that has helped Camden to reduce out-of-borough placements by 45% in the last five years.

Claudia - Cliff Road resident

4.2.3 Helping tackle gang culture

The Trust is part of an innovative multi-agency mental health-led project to help tackle gang culture along the Camden and Islington border.

Project 10/10 was set up in response to an upsurge of serious youth violence and criminal activity and targets hard-to-reach gang members with multiple complex needs and mental health problems and who refuse to engage with services.

The project team consists of a team lead and deputy - both C&I clinical psychologists - and three youth workers provided by Camden and Islington councils and voluntary sector partner Catch 22, and uses specialist approaches for working with gangs that place mental health at the heart of the intervention.

Currently, it is working with 60 young men and feedback to date is very positive.

The fundamental aims of the project are to reduce serious youth offending, enable young people to engage in training, to bridge them into mainstream services and to facilitate exit from gang-related activity.

Its approach is to give the young men genuine ownership and responsibility for the project - they named the project and designed its logo - and its codes of conduct. It supports them with a range of co-produced activities such as setting up a gym club, football team, driving and theory test projects, paintballing trips and a Christmas dinner.

It also helps the young people with their day-to-day needs in relation to housing, courts, probation, training and employment and also by working with their often chaotic family and personal life.

The project offers a place of safety for at least nine hours every week that is away from the atmosphere of hypervigilance, fear, threat and trauma that can dominate their lives. In addition, it models positive problem solving as an alternative to avoidance and anger.

A fun day out paintballing as part of the Gangs Project

4.3 Emergency preparedness and resilience

In accordance with both the Civil Contingencies Act 2004 and current NHS-wide guidance, the Trust has established plans to deal with major incidents and business continuity issues. They have been developed in consultation with regional stakeholders to ensure cohesion with their own plans.

The Trust has seen good developments in the Trust's resilience arrangements during the year and there will be more work at the service level to achieve full resilience.

4.3.1 Pandemic Influenza Plan

In line with NHS England requirements, the Trust has developed a plan to manage an outbreak of pandemic influenza in partnership with other health and social care organisations across Camden, Islington and the London region.

It was subject to particular 'deep dive' scrutiny during the annual Emergency Preparedness Resilience and Response (EPRR) preparedness assurance process conducted by NHS England (London) and was judged 'good' with a green RAG rating.

The prime objectives of the Plan are to save lives, reduce the need for hospital admissions, reduce the health impact, and minimise disruption to health and other essential services.

4.3.2 Testing and Exercising

The Trust is required to hold a live test every three years, a table-top test every year, and a communications cascade every six months.

Whenever possible, the Trust strives to ensure that its testing is held in a multi-agency context.

NHS England held a communications cascade exercise in April 2016. It was planned as a table-top major incident exercise focused on the 'Gold/Silver/Bronze' command process and the operational issues in a multi-trust mutual aid incident

In July 2016 the Trust held Exercise Alchemist, to test a comprehensive and co-ordinated response to a major incident based on a fire and arson scenario, and was extremely effective in allowing all stakeholders to fully appreciate the full capabilities and limitations of partners.

As required by the EPRR Core Standards, all corporate-level training and exercising is based on, and referenced to, the National Occupation Standards for Civil Contingencies.

4.3.3 Live Events

During 2016/17, C&I experienced a number of internal emergencies, with repeated failures in both IT and telephony provision. These were effectively and successfully managed using the London Emergency Services Liaison Panel (LESLP) command and control structures and significant lessons were learned.

As a result, when the Trust decided to replace significant parts of the IT infrastructure, a planning exercise in conjunction with other health trusts, and tenant organisations, produced a coherent process that maximised IT functionality, and minimised disruption.

A draft IT Systems Recovery Plan for the Trust has been created, and is awaiting approval.

A suspected WW2 bomb at a building site was dealt with as a potential multi-agency major incident. The Trust co-operated fully with other agencies in planning a large-scale evacuation, and particularly in managing the needs of service users and other vulnerable people in the community. The Trust's command and control protocols were fully tested, and the fully-developed plan validated the training the Trust has provided to managers at the strategic and tactical levels.

A major fire at the Highgate Mental Health Centre resulted in the loss of a significant number of beds. The effectiveness of the Trust-provided training was demonstrated when all affected service users were found beds at other locations within 12 hours, with the subsequent rapid re-commissioning of the ward following significant fire damage. A grade 2 level serious incident investigation followed, which commended the actions of staff, but made a total of 14 recommendations to assist in training for, and responding to, such incidents in the future.

The Trust has fully engaged in multi-agency terrorist-type exercises hosted by Camden and Islington Councils.

4.3.4 Partnership Working

The Trust works in collaboration with a range of partner agencies through formal standing meetings and ad hoc arrangements.

Formal committees of which the Trust is a member, include the Local Health Resilience Partnership and both the Camden and Islington Resilience Groups. The purpose of these groups is to ensure that effective and co-ordinated arrangements are in place for multi-agency emergency preparedness and response in accordance with national policy and direction from NHS England.

4.4 Data loss or confidentiality breaches

Patient confidentiality and security of information about service users is very important to C&I. Confidential information is held largely in electronic form in the Trust's electronic patient record system, CareNotes.

The Trust considers the risks to data security and appropriate actions to mitigate. All incidents which involve the loss or unauthorised disclosure of personal information are reported centrally and acted upon.

In addition to our incident management and reporting tools, the Trust uses the IG Toolkit Incident Reporting Tool to report level 2 IG SIRIs (Information Governance Serious Incidents Requiring Investigation) to the Department of Health, the Information Commissioner's Office and other regulators.

During 2016/2017, there were 84 incidents reported via the local reporting tool (Datix) for Information Governance. None of these incidents was reportable to the Information Commissioner's Office (ICO) and were managed following local protocol. In reviewing the types of breaches which had occurred, the incidents were mainly down to human error. Any Level 2 incident would be cascaded to the SIRO, which is the Director of Nursing, and reported on the IG toolkit as per the NHS Digital requirement. It will also be reported at the Trust's Information Governance Committee.

4.5 Public consultations

The Trust did not hold any public consultations in 2016/17.

4.6 Better payment practice code

The Trust aims to pay all invoices within 30 days, in line with the better payment practice code, and during 2016/17 made weekly payment runs to pay all invoices that were due for settlement.

4.7 Trust membership report

Over the past year, C&I has continued to focus on:

- **Building a sizeable and representative membership**
- **Developing an active and engaged membership**
- **Enhancing governance and accountability to the membership**
- **Ensuring continuous learning and improvement**

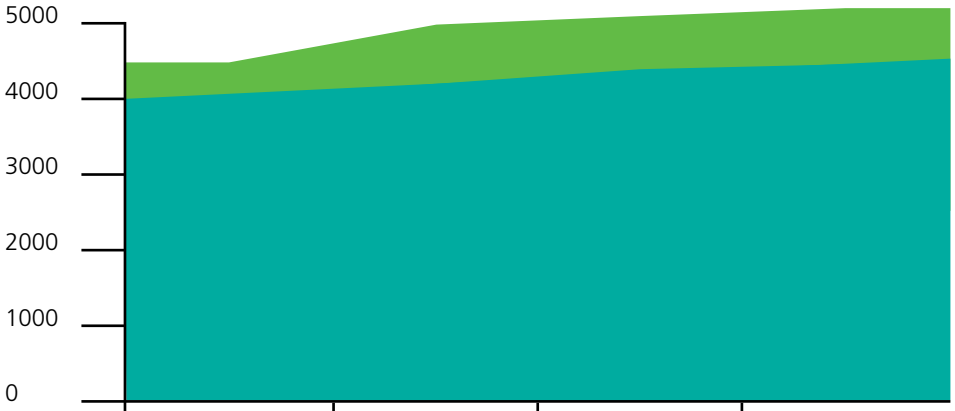
4.7.1 Growing a sizeable and representative membership

During 2016/17, the Trust's membership remained stable with the number of public members moving from 4,290 to 4,289 and its service user membership decreasing by just two, from 799 to 797.

Although the Trust fell short of its projected 2016/17 targets of 4,350 public members and 850 service user members, we exceeded our overall membership target of 5,000+ by maintaining 5,086 members during this period.

The Council of Governors has started looking at ways of more significantly growing the Trust membership and this work will continue in 2017/18.

Fig. 4.1
The Trust's membership remained stable in 2016/17 at over 5,000.



	31 March 2014	31 March 2015	31 March 2016	31 March 2017
Service User	463	743	799	797
Public	4010	4180	4290	4289

4.7.2 Diversity and representation

As part of the membership application process, individuals are asked to provide demographic data so the Trust can ensure its membership reflects the communities it serves. Whilst a sizeable proportion of applicants choose not to volunteer this information, the Trust regularly reviews available data to ensure that membership growth is as inclusive as possible.

Fig. 4.2
Age Group (% of Public Membership)
Breakdown of membership by age

Age Group	C&I	Local Population
0-16	0%	21%
17-21	4%	6%
22-29	12%	14%
30-39	13%	19%
40-49	13%	14%
50-59	11%	11%
60-74	10%	10%
75+	5%	5%
Unspecified	33%	0%

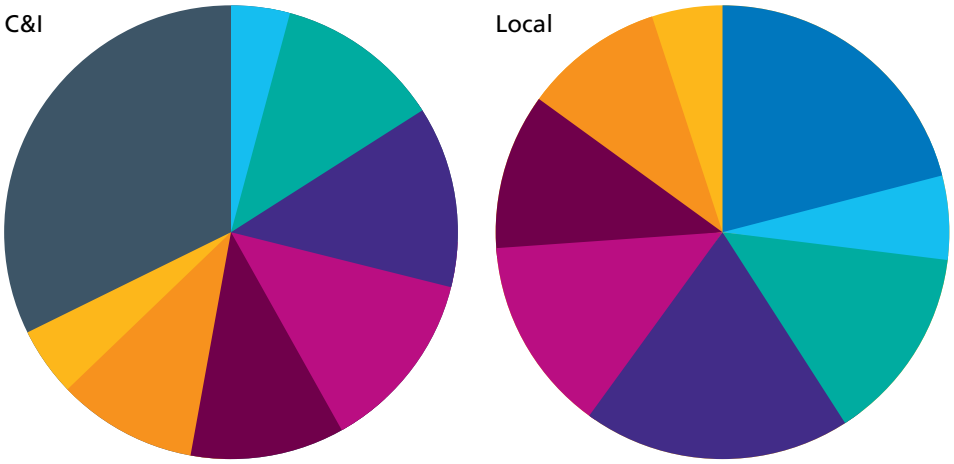


Fig. 4.3
Ethnicity (% of Public Membership)
Breakdown of membership by ethnicity

Ethnicity	C&I	Local Population
White	41%	59%
Mixed	5%	5%
Asian or Asian British	10%	18%
Black or Black British	8%	13%
Other	36%	5%

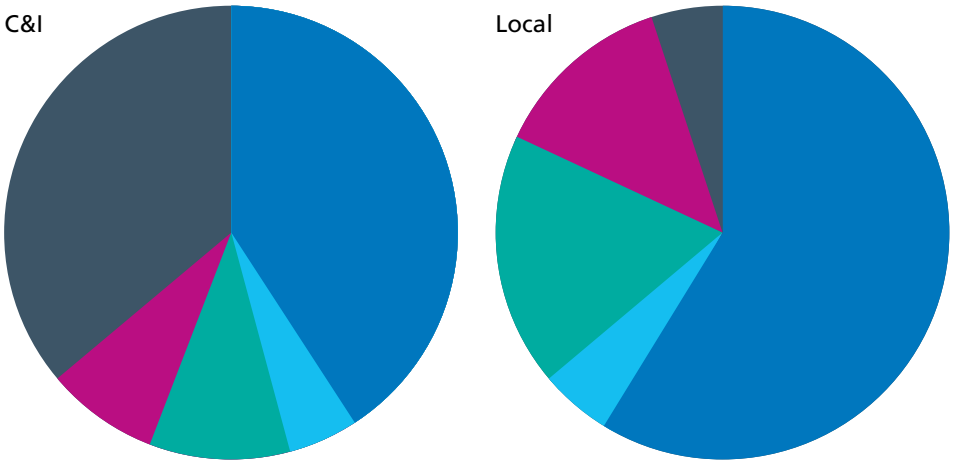


Fig. 4.4
Gender (% of Public Membership)
Breakdown of membership by gender

Gender	C&I	Local Population
Female	49%	50%
Male	49%	50%
Transgender	0%	0%
Unspecified	2%	0%

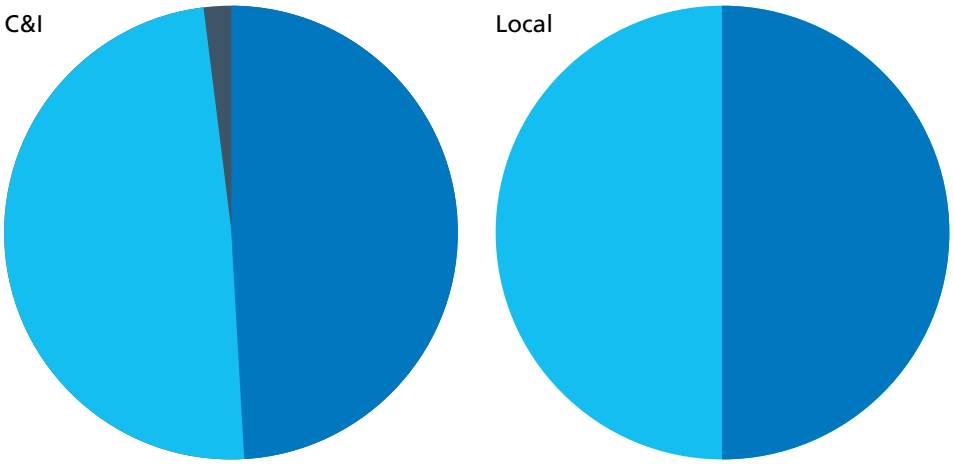
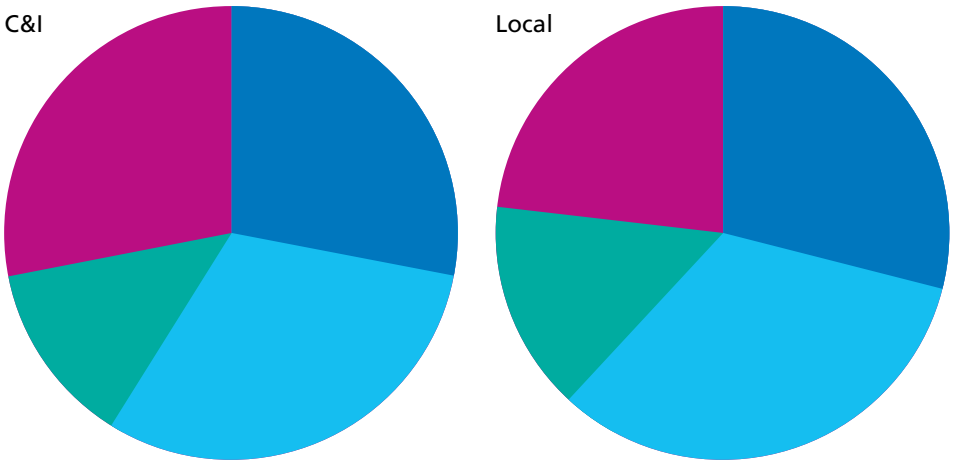


Fig. 4.5
Socio-Economic Group (% of Public Membership)
Breakdown of membership by Socio-Economic group

Socio-Economic Group	C&I	Local Population
AB	28%	29%
C1	31%	33%
C2	13%	15%
DE	28%	22%



All figures have been rounded up to the nearest whole percentage

In conclusion, C&I's membership remains broadly representative of the local population. The Trust will aim to increase the numbers of members who are aged 30-39 and will focus on growing members from Asian and Black backgrounds.

4.7.3 Developing and maintaining an active and engaged membership

Over 2016/17, the Trust hosted a number of events, improving engagement with members. This included four 'Mental Health Matters' events (previously known as Medicine for Members), featuring topics such as 'Seven Simple Steps to Quit Smoking' and 'Race Equality in Mental Health'.

Other notable events included Drayton Park's 21st birthday celebrations and the launch of C&I's community choir, which members were invited to join.

In addition, we held both our annual Open Day and our Members' Meeting, where new members were recruited.

4.7.4 Governance and Accountability

C&I is committed to building strong lines of communication, accountability and transparency between those who manage the Trust and the communities the Trust serves; as well as those between management and Trust staff. Membership is a fundamental part of our approach to achieving this aim and, as such, we continue to work hard to deliver improvements where possible.

Council of Governor Elections: During 2016/17, online elections were a significant part of electing new governors to the Council. The microsite, created specifically for the elections, improved accessibility and ease of voting, provided more detailed information about candidates and was an environmentally-friendly process.

Governor Training and Development: With University College London Hospitals (UCLH), C&I ran joint governor training sessions, providing its governors with an opportunity to enhance their skills and meet governors from another organisation. The training was delivered by NHS Providers as part of its GovernWell programme, and included modules such as Membership and Engagement, and NHS Finance and Business Skills.

The Trust's first News and Views session - September 2016

4.7.5 Learning and Improvement

Following on from the Trust's first Annual Members' Survey in 2015/16, the results were published in late 2016, which have led to significant improvements across the Trust. The Council of Governors' Membership Working Group reviewed the feedback from the survey and reported on the following key findings and developments:

What was asked?	What you said?	What we did?
Over the past 12 months, to what degree do you feel you have been kept informed about the Trust and opportunities for your involvement?	• 58.5% said 'well informed' • 32.3% said 'somewhat informed' • 9.2% said 'poorly informed'	C&I introduced a monthly 'Get Involved' email to improve communications with members.
Do you know who your Governors are and how to contact them?	• 47.7% said 'yes' • 52.3% said 'no'	• Governor information can be found on the Trust website, Annual Report and the Governors' Report • An email address has been set up for contacting governors: governors@candi.nhs.uk • Governors are asked to introduce themselves at the start of membership events
To what degree do you feel that C&I Governors are effective in representing the interests of the membership and the public within the Trust?	• 17.2% said 'very effective' • 32.8% said 'somewhat effective' • 17.2% said 'not effective' • 32.8% said 'don't know'	• The Membership Working Group has taken a lead on recruiting and meeting members • Governors report back to members on their activities through the Annual Governors' Report • Members who want to suggest general issues to be raised at Governor meetings can do so by emailing: governors@candi.nhs.uk
Do you have any thoughts on how C&I Governors can be more effective in representing the interests of the membership and the public within the Trust?	• More direct contact with members and members of the public • More information on governors and the work they do • Canvas members for ideas and points they wish to be raised at the Council of Governors' meetings	
What else would you like to see the Trust offer to members?	• More meetings, social activities or prevention/ lifestyle themed initiatives • Information on opportunities for service users • More information on new developments and key staff	• The Trust has increased the frequency and range of meetings, including the addition of C&I's new community choir • Information on events are sent through the Trust's membership database and included on the Trust website and quarterly magazine

4.7.6 Summary of eligibility requirements

C&I's membership comprises three constituencies: Public, Service Users, and Staff. Individuals are eligible to become members of one constituency, and those who are eligible to join the Staff Constituency cannot join as Public or Service User members while they are eligible for Staff membership.

Public membership: This constituency is divided into a further three constituencies: 'Camden', 'Islington' and 'Rest of London'. To be eligible for this membership, the individual must live in one of the three areas stated and be 16 or over.

Service User membership: To be eligible for this membership, the individual must have accessed one or more of the Trust's services within the last five years when they join and be 16 or over.

Staff Membership: This constituency is for individuals employed by the Trust permanently or under a contract exceeding one year. All staff are invited to become a member when their employment with the Trust commences and will automatically become one unless they choose to opt out.

4.7.7 Contact

Getting in contact with Governors:

Members who wish to contact governors can do so by emailing: governors@candi.nhs.uk, using the 'contact form' on the Contact page of our website or writing to:

Governors
Freepost RTGZ_ZKAY_XGGC
Camden and Islington NHS Foundation Trust
St. Pancras Hospital, 4 St Pancras Way
London
NW1 0PE

Getting in contact with the Trust Board:

Members who wish to contact the Board can do so by emailing: Trust.Secretary@Candi.nhs.uk or by writing to:

C&I Board
Freepost RTGZ_ZKAY_XGGC
Camden and Islington NHS Foundation Trust
St. Pancras Hospital, 4 St Pancras Way
London
NW1 0PE

Getting in contact with the Membership Office:

Members who wish to contact the Membership Office can do so by emailing: membership@candi.nhs.uk or by writing to:

Membership Office
Freepost RTGZ_ZKAY_XGGC
Camden and Islington NHS Foundation Trust
St. Pancras Hospital, 4 St Pancras Way
London
NW1 0PE

4.8 Our governance

Camden and Islington NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

Our governance arrangements are led by the Trust Chair, Leisha Fullick. Leisha is the Chair of our Board of Directors and the Council of Governors.

4.8.1 Board of Directors

Our Board provides overall leadership and vision to the Trust and is collectively responsible for all aspects of performance and management of the Trust's activities, including clinical and service quality, financial performance and governance.

The Board operates according to the values of the Nolan principles (selflessness, integrity, objectivity, accountability, openness, honesty and leadership).

The Board of Directors comprises:

- A non-Executive Chair
- Six non-Executive Directors
- Seven Executive Directors (Two non-voting)

In accordance with our constitution, the Executive Directors must include the Chief Executive (as the accounting officer), the Finance Director, a registered medical practitioner, and a registered nurse. The Trust Company Secretary also attends Board meetings in a non-voting capacity.

The expertise of the non-Executive Directors includes finance, human resources, estates, marketing, strategic property development, equality and diversity, and management consultancy. The names, roles, and a description of the background of each Director are shown later.

All Directors are signatories to the Code of Conduct for NHS Boards and Code of Accountability for NHS Boards of Directors. In March 2015, the Board of Directors adopted a revised Code of Conduct, incorporating the new regulations relating to Duty of Candour and Fit and Proper Persons. This document also sets out the key responsibilities of Board Directors and their responsibilities in relation to the Council of Governors.

The Board delegates the operational management of the organisation to the Chief Executive and the Foundation Trust Executive Committee, which includes the Executive Directors.

The Trust has a scheme of delegation which sets out the types of decision to be delegated to managers by the Board ('Reservation of powers to the Board and delegation of powers').

The Board believes it has a balanced, complete and appropriate membership in line with the requirements of being an NHS foundation trust.

4.8.2 Conflict of Interest and Register of Interests

The Trust maintains a formal register of Directors' interests, available for inspection, on request, at the Foundation Trust Headquarters at St Pancras Hospital, Executive Offices, 4th Floor East Wing, 4 St Pancras Way, London NW1 0PE (telephone 020 3317 7112). The Register of Interests for Directors can also be viewed by members of the public, via the Trust's website: (On our website click on About us, Who we are, then Our Board).

Board members do not hold directorships in companies with whom the Foundation Trust has done business within this financial year and each non-Executive Director is required to confirm that they remain independent. This is also considered by the Council of Governors when they appoint or re-appoint non-Executive Directors. The Trust considers that all non-Executive Directors are independent.

4.8.3 Council of Governors

The Council of Governors has a number of statutory responsibilities described in the Trust's constitution. These include some additional powers as a result of amendments to the 2006 Act made by the 2012 Health and Social Care Act. The specific statutory powers and duties of the Council of Governors are to:

- Develop our membership and represent the interests of the members of the Trust as a whole and the interests of the public;
- Contribute to the development of the Trust's strategy and forward plans;
- Appoint and, if appropriate, remove the Chair and the other non-Executive Directors. The Council of Governors' Nominations and Remuneration Committee is responsible for overseeing the procedure of the removal of a non-Executive Director. This procedure is set out in the Trust's constitution;
- Discuss and agree the outcome of the Chair's appraisal;
- Decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other non-Executive Directors;
- Approve the appointment of the Chief Executive;
- Appoint and, if appropriate, remove the Trust's Auditor;
- Receive the Trust's Annual Accounts, any report of the Auditor on them and the Annual Report;
- Hold the non-Executive Directors, individually and collectively, to account for the performance of the Board of Directors;
- Approve significant transactions, as defined in the Trust's constitution;
- Approve an application by the Trust to enter into a merger, acquisition, separation or dissolution;
- Decide whether the Trust's non-NHS work would significantly interfere with its principal purpose; and
- Approve amendments to the Trust's constitution.

During the year, the Council exercised many of these duties. In particular, the Council approved the appointment of two new non-Executive Directors and the re-appointment of the Trust Chair and an existing non-Executive Director. It also reviewed and set remuneration levels for the Chair and other non-Executive Directors, and received the Annual Report and Accounts.

The Council has continued to play an important role in helping to shape the strategy of the Trust, and provides feedback to the Trust on the views of members and the public on its forward plan, including objectives, priorities and strategy. It also holds the non-Executive Directors, individually and collectively, to account for the performance of the Board through the Governor-led working groups which have at least one non-Executive Director as a member of each group. Each working group has agreed objectives, and a focus on one of the following areas of Trust performance:

- Service User and Staff Experience and Quality;
- Membership;
- Finance and Business Planning; and
- Development of the St Pancras Hospital site.

The Council also had a major focus in the past year on the outcome of the Care Quality Commission's full inspection and the related action plans, and on issues relating to bed pressures and hospital discharge.

4.8.4 Constituencies of the Council of Governors:

- Public constituency;
- Service user constituency;
- Staff constituency; and
- Appointed Governors.

4.8.5 Composition of the Council of Governors:

The Council of Governors currently comprises 21 elected Governors and five appointed by stakeholder and partner organisations, as shown below:

- Six elected by service user members;
- Eleven elected by members of public constituencies;
- Four elected by C&I staff;
- Five appointed by partnership organisations (the Trust constitution provides for up to eight appointed governors).

4.8.6 Governor Elections

Elected Governors normally hold office for periods of three years and are eligible for re-election at the end of their first term. An elected Governor may not hold office for more than nine consecutive years. Therefore, if they have already served more than six years at the time of new elections, they would not be allowed to stand again.

Governor elections were held in 2016 to fill eight vacancies across three constituencies as follows:

- two service user Governors;
- four public Governors; and
- two staff Governors.

All positions were filled. In addition, two new Appointed Governors joined the Council of Governors in 2016.

4.8.7 Governor Vacancies

One existing Public Governor left the Trust soon after the 2016 elections and was replaced by the next-in-line nominee within the same constituency. In addition, one Staff Governor left the Trust in early 2017 and this post remained vacant at 31 March 2017. A by-election to fill this post will be held in early 2017/18.

Islington mayor, Kat Fletcher, and Camden mayor, Nadia Shah, enjoy the Trust Open Day

4.8.8 Name and description of constituencies and organisations appointing Governors during 2016/17

Public constituency - comprises members of the public who reside in any of the 18 electoral wards in the London Borough of Camden, the 16 electoral wards in the London Borough of Islington, and all electoral wards within the City of London and the remaining 30 principal subdivisions of the administrative area of Greater London, each governed by a London borough council, established by the London Government Act 1963.

Staff constituency - comprises staff employed by the Trust under a contract of employment which has no fixed term or has a fixed term of more than 12 months; or have been continuously employed by the Trust under a contract of employment for at least 12 months.

Service user constituency - comprises anyone who has been a service user of the Trust within the last five years at the point of application for membership, or is over the age of 16 and provides care on a regular basis for a service user who has not attained the age of 16 or who is, by reason of physical or mental incapacity, unable to discharge the functions of a member.

Voluntary Action Camden (VAC) is an independent, grant-aided voluntary organisation that exists to support, encourage, defend and develop voluntary and community action in the London Borough of Camden.

Voluntary Action Islington (VAI) is Islington's umbrella agency for the voluntary sector and the main provider of support for local voluntary organisations.

London Borough of Camden (LBC) - is the local authority for Camden (currently vacant).

London Borough of Islington (LBI) - is the local authority for Islington.

University College London (UCL) - Division of Psychiatry, which is part of a consortium of Mental Health Sciences.

4.8.9 Council of Governor Meetings

Governors are expected to attend Council of Governor meetings and there are provisions in the constitution relating to non-attendance at three consecutive meetings. Directors attend Council meetings on a regular basis, particularly if there is a topic being discussed which falls under their portfolio of responsibilities.

Four Council of Governor general meetings were held during 2016/17 on the following dates:

- 10 May 2016;
- 13 September 2016;
- 13 December 2016; and
- 14 February 2017

The Council of Governors has not exercised its power under paragraph 10C of Schedule 7 of the NHS Act 2006, as amended by section 151(8) of the Health and Social Care Act 2012, to require one or more directors to attend a governors' meeting.

4.8.10 Terms of office and meeting attendance

Governor current term of office and their attendance at the four general meetings of the Council of Governors held during 2016/17 are reported below:

Council of Governors' Terms of Office and Meeting Attendance Record

Name	Elected/ Appointed	Term for which elected/ appointed	Constituency or appointing organisation	General Council Meeting Attendance
Dr Zaheer Afridi	Elected	2016-2019	Camden public	2/2
Ms Hagir Ahmed	Elected	2015-2018	Service user	4/4
Mr Shahnewaz Ahmed (Resigned May 2016)	Elected	2013-2016	Camden public	1/1
Ms Ruth Appleton	Elected	2013-2016	Camden public	1/2
Ms Julia Austin	Elected	2016/2019	Service user	1/2
Mr David Barry (Lead Governor)	Elected	2015-2018	Islington public	4/4
Ms Maureen Brewster	Appointed	2014-2017	Voluntary Action Camden	1/4
Ms Doris Daly	Elected	2015-2018	Islington public	2/4
Ms Melanie Dunn	Elected	2015-2018	Service user	0/4
Ms Bamidele Esuola	Elected	2015-2018	Service user	2/4
Ms Valerie Graham	Elected	2015-2018	Islington public	4/4
Ms Debra Hall	Elected	2015-2016 2016-2019	Staff	1/4
Prof Angela Hassiotis	Appointed	2014-2017	University College London Medical School	1/4
Ms Jane Jacks (Resigned April 2017)	Elected	2016-2019	Service user	0/2
Ms Farah Khan	Elected	2016-2019	Camden public	0/2
Cllr Jean Kaseki	Appointed	2013-2016	London Borough of Islington	1/2
Ms Rachel Kent	Elected	2016-2019	Staff	1/2
Mr Alasdair Macdougall	Elected	2013-2016	Service user	2/2
Ms Suncica Mandich	Elected	2015-2018	Camden public	1/4
Ms Lucy Mclean (Resigned June 2016)	Elected	2015-2018	Staff	1/1
Mr Andy Murphy	Appointed	2014-2017	Voluntary Action Islington	1/4
Ms Michelle Murray	Elected	2015-2018	Camden public	4/4
Ms Saira Nawaz	Elected	2013-2016 2016-2019	North Central London	2/4
Ms Sarah Papworth-Heidel (Resigned February 2017)	Elected	2016-2019	Staff	1/2
Mr Andrew Pike (Resigned September 2016)	Elected	2015-2018	Camden public	2/2
Mr Simon Ramage	Elected	2015-2018	Staff	3/4
Ms Larraine Revah	Appointed	2016-2019	London Borough of Camden	0/2
Professor Wendy Savage	Elected	2015-2018	Islington public	4/4
Ms Monika Schwartz	Elected	2013-2016 2016-2019	Islington public	3/4
Ms Catherine Steven (Stood down May 2016)	Elected	2014/2016	Service user	0/1
Ms Gunanganie Wijeweera	Elected	2017/2018	Camden public	0/1

4.8.11 Committees of the Council of Governors

The Council of Governors has operated with two standing committees during 2016/17, which were a statutory joint Nominations and Remuneration Committee, and a locally-determined Council of Governors' Steering Committee.

The membership of the Nominations and Remuneration Committee is detailed below:

Membership and meeting attendance

Members	Role	Attendance
Professor Wendy Savage	Public Governor, Islington (Committee Chair)	5/5
Ms Leisha Fullick	Trust Chair (Committe Vice Chair)	5/5
Ms Ruth Appleton	Public Governor, Camden	2/3
Mr David Barry	Public Governor, Islington (Lead Governor)	4/5
Ms Angela Harvey (from May 2015)	Non-Executive Director	4/5
Ms Lucy McLean	Staff Governor	0/2
Simon Ramage	Staff Governor	2/2

4.8.12 Work of the Council of Governors' Nominations and Remuneration Committee in 2016/17

The Nominations and Remuneration Committee recruited a new non-Executive Director to replace Mr Richard Brooman who ended his term of office during the year. The committee also led on the appointment of two further non-Executive Directors, Professor Tom Burns and Mr Kieran Parmar, during this period. The committee also re-appointed Trust Chair, Ms Leisha Fullick, and non-Executive Director Ms Angela Harvey. Annual reviews of performance and pay were undertaken in year.

The Council of Governors' Nominations and Remuneration Committee is responsible for overseeing the procedure of the removal of a non-Executive Director. This procedure is set out in the Trust's constitution.

4.8.13 Council of Governors' Steering Committee

The Council of Governors' Steering Committee met on four occasions to oversee the scheduling, agenda planning and general arrangements for the Council of Governor meetings. This committee is chaired by the Lead Governor, with governor representation invited from all constituencies. The Trust Chair, Senior Independent Director and Chief Executive are also members of this committee. The Committee meets approximately six weeks in advance of each general meeting of the Council.

4.8.14 Conflict of Interest and Register of Interests

Governors are required to register with the Trust any details of company directorships or other material interests in companies held by Governors, where those companies or related parties are likely to do business, or are possibly seeking to do business, with the Trust. The register is available for inspection, on request.

The Register of Interests for Governors can be accessed by members of the public, via the Trust's website: (On our website click on About Us, Who We Are, then Our Governors).

4.8.15 The NHS Foundation Trust Code of Governance

Camden and Islington NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'Comply or Explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

This code, published by NHS Improvement, brings together best practice from the private and public sectors. It provides an overarching framework for corporate governance and complements the statutory and regulatory obligations placed on Foundation Trusts. The Trust considers that it has applied the principles of the Code of Governance.

4.8.16 Our Board of Directors

During 2016/17 there were a number of changes to the Board of Directors. The year started under the leadership of a new Chief Executive, Ms Angela McNab. Towards the end of the year Deputy Chair and Chair of the Audit and Risk Committee, Mr Richard Brooman, reached the end of his allowable term of office and was replaced by new non-Executive Director, Mr Kieran Parmar, who also took over the Chair of the Audit and Risk Committee. Professor Tom Burns joined the Board as a non-Executive Director at the start of October 2016.

On the Executive side, Chief Operating Officer and Deputy Chief Executive, Mr Paul Calaminus, left the Trust at the end of February 2017. His deputy, Mr Andy Stopher, has been Acting Chief Operating Officer in his absence and a new permanent officer, Mr Andy Rogers, will take up this post in May 2017. Director of Nursing & People, Ms Claire Johnston, left the Trust in February 2017 on a secondment to work on strategic nursing workforce issues, leading delivery of the Capital Nurse programme, in partnership with the North Central London Strategic Transformation Plan (NCL STP). Deputy Director of Nursing, Ms Caroline Harris-Birtles, has acted up following her departure.

Following a review of executives' portfolios, Ms Sally Quinn was appointed Acting Director of Human Resources and Organisational Development from January 2017.

4.8.17 Board meetings

The Board met in public on eight occasions during the year followed by a private and confidential meeting on each occasion, plus one additional private session. It also held a number of seminars and away days as part of its Board development programme. Board papers for the meetings held in public are published on the Trust website.

The Board agenda is agreed by the Chair and Chief Executive. The agenda includes regular service user stories, feedback from service visits and a range of reports on quality, performance, strategic and operational issues presented by the Executive Directors, as well as reports from the non-Executive Chairs of the sub-committees of the Board.

During the year, the Board focused on a number of priority areas, including:

- Hearing directly from service users about their experience of Trust services;
- Monitoring the Trust's response to significant demand and capacity pressures during the year;
- Strategic options for future development, growth and sustainability;
- Refreshing the Trust's Board Assurance Framework and monitoring material risks;
- Quality and financial performance and improvements;
- Development of new Patient Experience and Service User Involvement Strategies;
- Responding to, and monitoring, issues raised by the CQC or from service user and staff surveys;
- The strategic options in relation to the Trust's estate, including the development of the St Pancras Hospital site and North Central London Transformation and Sustainability plans;
- The replacement of the Trust's electronic patient record; and
- Strengthening the transparency, engagement and effectiveness of the Board and Council of Governors.

In addition, the Board received a range of annual reports and a regular report from the Chief Executive on the business of the Executive Management Committee, including strategic and service updates and the use of the Trust Seal.

It also received a range of reports and views from the Council of Governors.

Board meeting attendance

Board Member	Meetings attended
Leisha Fullick	8/8
Angela McNab	8/8
Pippa Aitken	8/8
Richard Brooman	6/7
Tom Burns	4/4
Paul Calaminus	7/7
Susan Goss	8/8
Caroline Harris-Birtles	1/1
Angela Harvey	7/8
Claire Johnston	7/7
Dr Vincent Kirchner	8/8
Sally Quinn	2/2
Andy Stopher	1/1
Darren Summers	8/8
Patrick Vernon	8/8

Leisha Fullick
Trust Chair

Leisha Fullick was first appointed on 1 September 2013 for a three-year term. She is now well into her second term having been re-appointed for another three-year term which ends on 31 August 2019.

Leisha has had significant Board and executive experience in a variety of roles. She is well known locally from her time as Chief Executive of Islington Council from 1996-2002. Her background is in education and she has served on a number of national bodies, as well as an Inspector and Director of Education in London and as Pro Director, Institute of Education, and University of London.

Her particular skills are in strategy, leadership, corporate governance and community engagement. She is passionate about lifelong learning, which she sees as very relevant to the mental health agenda. Leisha also has considerable experience of partnership working and in her current role is working closely with other NHS bodies, police, local authorities and the voluntary sector to achieve more and better mental health services, locally and nationally.

She is deeply committed to human rights and equality of opportunity and to ensuring that organisations with which she is associated are as service user-focused, open, and transparent as possible.

Angela McNab
Chief Executive Officer

Angela McNab joined the Trust in April 2016. She has extensive experience at Chief Executive-level, most recently at Kent and Medway NHS and Social Care Partnership Trust.

Among her previous senior and high-profile roles, she has been Chief Executive at NHS Luton and NHS Bedfordshire and worked as Director of Public Health, Delivery and Performance, at the Department of Health. Angela also led the Human Fertilisation and Embryology Authority for five years.

Angela puts a strong emphasis on engagement and involving clinicians, service users and carers in developing and improving services. She has a particular interest in developing culture in organisations and in strategic leadership, and is a qualified executive coach.

Pippa Aitken
Non–Executive Director

Pippa Aitken was appointed on 1 May 2015. Her current term of office ends on 30 April 2018.

She has a background in property and planning, having worked in both the public and private sector. She is a member of the Trust's Strategic Development Committee, which has a major responsibility relating to the Trust's site redevelopment. Her involvement includes appointing property advisers to assist with the project.

In addition, she is helping to review the Trust's Estates Strategy, ensuring it is fit for purpose. She is also a member of the Trust's Audit and Risk Committee.

Pippa has a wealth of experience as a non-Executive Director and public sector committees through her role on the Finance and Development Committee of a large, successful housing association, Family Mosaic.

Alongside her executive career, Pippa has undertaken some voluntary work and is a Governor for Villiers High School in Southall. Pippa has a strong interest in young people and in issues of diversity.

Richard Brooman
Deputy Trust Chair
and Non-Executive Director
until February 2017

Richard Brooman was appointed in March 2009 and re-appointed in March 2011 for a three-year term up to the end of February 2014. He was re-appointed for a final three year term which ended in February 2017. Richard also served as Deputy Chair of the Trust from May 2015.

Richard is a chartered accountant with over 25 years board-level and senior management experience in large and complex organisations and is a previous Chief Financial Officer of the global consumer healthcare division at SmithKline Beecham Plc. He has additional experience in non-Executive and Senior Independent Director roles.

Tom Burns CBE
Non-Executive Director

Tom Burns was appointed as a non-Executive Director in October 2016, following experience of this role at two other mental health trusts.

He worked as a consultant psychiatrist for 10 years before becoming a professor of social psychiatry, first at St George's Medical School in London and then at the University of Oxford. He retired two years ago and now lives in Islington.

Being a professor of social psychiatry means that he has been able to travel and observe different services nationally and internationally. His research has focused on testing the value of different forms of services for people with severe mental illnesses, mainly psychoses. He believes such research is essential to distinguish service changes that benefit patients from those that really do not.

Tom trained as a group analyst and continues to believe that psychotherapy is an essential component of all psychiatry.

He was awarded a CBE for services to mental health in 2006.

Paul Calaminus
Chief Operating Officer and Deputy Chief Executive until February 2017

Paul was Chief Operating Officer with responsibility for operational service delivery in the Trust from January 2013 to February 2017 when he left to take up the role of Chief Operating Officer at East London NHS Foundation Trust. He was also deputy chief executive at the Trust from August 2015.

Previously, he worked as a Service Director at South London and Maudsley NHS Foundation Trust for six years. Prior to this he held a number of management roles at the same Trust, including developing its Foundation Trust application.

Paul is a graduate of the NHS management training scheme, and has worked in mental health services management since 1997.

Sue Goss
Non-Executive Director

Sue Goss was appointed in June 2012 and re-appointed for a second three year term in May 2015. Her current term of office expires in May 2018.

She chairs the Board's Quality Committee, which is responsible for safety, quality and patient experience, and serves on the Audit and Risk Committee. Sue supports the Trust to cope with reduced resources, a high demand for beds and problems with recruitment, while at the same time maintaining safety, improving care planning and ensuring people know their rights.

She has worked extensively with local authorities, health organisations and partnerships on service improvement, and is currently supporting leadership across a number of health and social care systems. Sue has experience of design, co-production and user engagement as well as equality and diversity strategies.

Her career has involved working in politics, the community and the voluntary sector, and as an academic. She has previous experience as both an Executive and non-Executive Board member, as a Board member of OPM (a research organisation and consultancy), the Chair of Charter 88, the Chair of the Commission on Active Citizenship and Public Services, and a non-Executive Regional Board member for the Guinness Trust.

Caroline Harris-Birtles
Acting Director of Nursing

Caroline joined the Trust in May 2015. She trained as a registered mental health nurse as a mature student at Ealing School of Nursing, West London, and has worked across a range of mental health services over the last 30 years.

Her areas of expertise include forensic care, children's services, eating disorders and services for the deaf as well as general adult and older persons' psychiatry. Her experience includes working in the local authority, private and charity sectors.

Caroline has held senior roles in operational management, professional nursing leadership and Quality Governance and has deep knowledge of working with service users and carers. Particular interests include service user safety, safe staffing, new nursing roles, and physical health care for service users with mental health issues.

She has trained in Heath Care Quality Improvement Methodology and Research Methodology in Health and Social Care at the University of Gloucestershire.

She was appointed Acting Director of Nursing from 3 February 2017.

Angela Harvey
Non-Executive Director
and Senior Independent Director

Angela Harvey FCIPD FRSA, was appointed on 1 September 2013 for a three-year term to 31 August 2016. She has been re-appointed for another three-year term ending on 31 August 2019.

Angela is Chair of the Resources Committee, and sits on the Remuneration, and the Nomination committees. The Resources Committee tests and supports how Finance, Workforce, IT and Estates are managed, ensuring these resources benefit the Trust's service users, staff and local community. Since 12 January 2016, Angela has been the Senior Independent Director whose role includes working closely with the Council of Governors.

Angela is a local councillor in Westminster, currently Chair of Licensing, and with wide experience in housing, planning and the built environment. Her responsibilities have included the rough sleeper strategy through which over 1,600 people every year were helped back towards independent living. She also sponsored the Westminster Housing Commission. Angela was Lord Mayor of Westminster 2012-2013 and served for the Diamond Jubilee as well as the Olympics and Paralympics. She chairs the Staff Appeals Panel and is a non-Executive Director of CityWest Homes. She is a trustee of two charities.

As an HR professional, she has a strong strategic background across the private, public and third sectors. She is a trained Executive Coach, and is also Chair of a not-for-profit private housing board.

Claire Johnston
Director of Nursing and People until February 2017

Claire Johnston was Director of Nursing and People, previously Director of Nursing and Performance, from July 2002 until February 2017 when she left the Trust to take up a secondment.

She has significant experience of Trust Boards, operating at a Director-level for 15 years and representing nurses, psychologists, occupational and other therapists, and social workers. Her further responsibilities have included patient safety, clinical risk and quality assurance, in addition to Human Resources, and Learning and Organisational Development.

She has worked in a range of clinical and teaching roles in nursing before becoming a National Adviser in Primary Care and Community Health Nursing at the Royal College of Nursing.

Claire is a Clinical Professor of Nursing at Middlesex University's Institute of Nursing, Midwifery and Social Work.

In February she took a secondment to lead the delivery of the Capital Nurse programme in North Central London, as part of the Sustainability and Transformation Plan, and has now left the Trust.

Dr Vincent Kirchner
Medical Director

Dr Vincent Kirchner has been the Medical Director for C&I since 1 April 2015 and has worked in mental health services for around 25 years.

He studied medicine in South Africa, started his specialist psychiatric training in 1992 and has worked in mental health since then. He emigrated to the UK in 1996 and completed his psychiatric training in East London, joining C&I as a consultant in 2000.

His various roles have included lead consultant, associate medical director and deputy medical director. He is a graduate of the NHS Leadership Academy's Nye Bevan programme.

Vincent is responsible for the professional aspects of the medical workforce including the appraisal processes that support the revalidation of doctors employed by C&I. He is also responsible for C&I's clinical strategy and committed to C&I delivering high quality services that result in good patient experience, good clinical outcomes and ensure the delivery of the safest care possible.

He is driving one of the Trust's key strategic aims for developing research and innovation, working with its academic partners at University College London.

Kieran Parmar
Non-Executive Director

Kieran Parmar joined the Trust in Mach 2017, as both a non-Executive Director and Chair of the Audit Risk Committee. As a chartered accountant, he has extensive experience of delivering transformational change in finance, business development and commercial director roles in large complex organisations.

He has also served as a non-Executive Director on North West London Hospitals Trust's Board, as well as being its Deputy Chairman for three years.

As Chair of the Audit and Risk Committee, his focus is on safeguarding and protecting the Trust, its Board, officers, staff and service users. This will be done by providing the Board with assurance that the Trust has a well-led governance framework, which delivers quality, has robust and reliable systems of control, manages risk well, and delivers its statutory reports and declarations with integrity.

Sally Quinn
Acting Director of Human Resources and Organisational Development

Sally Quinn joined the Trust in April 2016 as the Associate Director of Human Resources and Organisational Development.

She has over 20 years' experience in Human Resources and Organisational Development and change management. Prior to joining C&I, she was Deputy Director of HR and OD at another London trust for several years and has also worked in two national roles for an NHS arm's length body.

Particular areas of interest and expertise are workforce planning, performance development, talent management, OD and staff engagement.

She is a Chartered Fellow of the Chartered Institute of Personnel and Development.

Sally was appointed Acting Director of Human Resources and Organisational Development from January 2017.

Andy Stopher
Acting Chief Operating Officer

Andy Stopher joined the Trust in the mid-nineties and has had many roles across substance misuse and mental health, including Director of the Trust's Substance Misuse Service and Recovery and Rehabilitation divisions.

He has been Deputy Chief Operating Officer since 2016 and was Acting Chief Operating Officer from 1 March 2017.

Andy originally trained as a general nurse and then a mental health nurse. He is a qualified psychoanalytic psychotherapist.

Darren Summers
Director of Strategy and Business Development

Darren Summers joined the Trust in February 2016. He started his career working in homeless services, including rough sleeper and young people's hostels, a mental health street outreach team and managing a hostel for asylum seekers.

He spent ten years commissioning mental health and social care services, initially in Tower Hamlets and then also in Hackney and Newham.

Darren joined the Trust from Family Mosaic Housing Association, where he was Director of Growth and Transformation in the care and support division.

Patrick Vernon OBE
Non-Executive Director

Patrick Vernon was appointed on 5 October 2015. His current term of office ends in October 2018.

Patrick Vernon is a Clore Fellow with the Clore Leadership Programme to develop cultural leaders and an Associate Fellow at Warwick University's Department of History of Medicine. He is a Health Partnership Coordinator for the National Housing Federation, and a former committee member of Healthwatch England and NHS England Equality Diversity Council. He has also been an Advisory Board member for the Time To Change movement on mental health and former adviser to Labour and coalition governments on mental health.

Amongst many public and charity sector roles, Patrick has worked as a senior civil servant at the Department of Health, is a former Director of the Brent Health Action Zone (Brent Primary Care Trust) and a former regional director for MIND, North West London Community Foundation and The Afiya Trust. Patrick is also a former non-Executive Director for East London & the City Health Authority, and Independent Chair of Westminster Partnership for Race Equality where he played a key role with the Metropolitan Police and the Muslim community with the aftermath of the 7/7 attack in Westminster. Patrick is a trustee of Social Action for Health and North London Muslim Housing Association in Hackney, and Patron of Santé, a refugee social enterprise based in Camden.

Patrick was awarded an OBE for his work in tackling health inequalities for ethnic minority communities in Britain in 2012.

David Wragg
Finance Director

David Wragg joined C&I in October 2012 and has responsibility for estates and facilities management, health and safety, and Information and Communications Technology (ICT), as well as the Trust's finances.

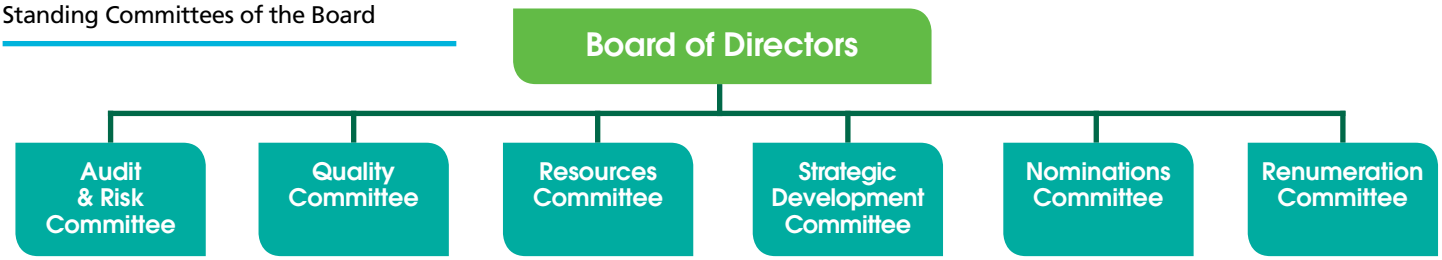
Prior to joining Camden and Islington, he gained 13 years of Board-level experience as Finance Director in two other London Trusts. He has also worked in management consultancy and external audit with NHS and other health bodies.

David has contributed to expert NHS committees and has been a Director in an NHS-owned joint venture company. He is a professionally qualified accountant, a member of the Chartered Institute of Public Finance and Accountancy.

4.8.18 Board of Directors' Sub-Committees and Attendance

The Board met in public on eight occasions during the year followed by a private and confidential meeting on each occasion, plus one additional private session. It also held a number of seminars and away days as part of its Board development programme. Board papers for the meetings held in public are published on the Trust website.

Standing Committees of the Board



4.8.19 Quality Committee

Committee Membership

The Quality Committee membership comprises a non-Executive Director Chair, two further non-Executive members and four Executive Directors including the Chief Executive, the Deputy Chief Executive/ Chief Operating Officer, Medical Director and the Director of Nursing and People. Senior officers of the Trust including the Associate Director, Governance and Quality Assurance and the Head of Social Work and Social Care also regularly attend.

The Committee met six times in 2016/17.

Quality Committee members and attendance

Members	Meetings attended
Dr Susan Goss (Committee Chair) Non-Executive Director	5/5
Professor Tom Burns Non-Executive Director Since January 2017	1/1
Patrick Vernon Non-Executive Director	2/5
Angela McNab Chief Executive	5/5
Claire Johnston Director of Nursing and People and Executive Lead for the Quality Committee	4/5
Dr Vincent Kirchner Medical Director	4/5
Paul Calaminus Deputy Chief Executive/Chief Operating Officer	5/5

Roles and duties

The role of the Quality Committee is to:

- Ensure that quality, healthcare and social care outcomes are the focus of the Trust's activity;
- Make the three core healthcare outcomes of safety, effectiveness and service user experience central to the development, delivery and measurement of the Trust's care and services;
- Provide assurance to the Trust's Board of Directors that standards of performance and policy changes in relation to quality, healthcare and social care outcomes are met;

- Monitor equality and diversity and ensure appropriate action is taken to improve equality;
- Ensure effective safeguarding across the Trust;
- Ensure that learning and development needs are identified and appropriately met from clinical governance, risk and audit programmes; and
- Oversee the Trust's key programmes in related areas.

Work of the Committee in 2016/17

Through its six meetings in 2016/17 the Quality Committee has:

- Maintained oversight of the outcomes of the Care Quality Commission inspection and action plans developed following the Commission's visit in February 2016;
- Considered regular updates on service user and carer involvement and monitored the implementation of related actions;
- Considered the violence and aggression report with a further deep dive study on violence and aggression on inpatient wards;

Overseen the development and approval of the following:

- Equality and Diversity Strategy
- The Clinical Strategy implementation
- The Mental Health Law, Medicines and Research and Development of annual reports
- Overseen the introduction to Quality Improvement

4.8.20 Strategic Development Committee

Committee Membership

The Strategic Development Committee's membership comprises a non-Executive Director Chair; one further non-Executive member; and five Directors - including the Chief Executive, Medical Director, Chief Operating Officer, Director of Finance and Director of Strategy and Business Development. Regular attendees include the Project Director of St Pancras Hospital and programme managers where appropriate.

Meeting attendance

The Committee met six times in 2016/17. Attendance was as follows:

Strategic Development Committee members and attendance

Members	Meetings attended
Leisha Fullick, Trust Chair Committee Chair	6/6
Pippa Aitken Non-Executive Director	6/6
Angela McNab Chief Executive	6/6
Vincent Kirchner Medical Director	5/6
Paul Calaminus Chief Operating Officer	5/5
David Wragg Director of Finance	5/6
Darren Summers Director of Strategy & Business Development	6/6

Roles and duties

The role of the Strategic Development Committee is to:

- Lead the implementation of the Trust's five-year strategic plan and drive the underpinning growth strategy and major strategic developments to support the sustainability of the Trust; and
- Act as the Programme Board for the St Pancras Hospital site development.

The main duties of the Strategic Development Committee are:

- To oversee the implementation of the five-year Strategic Plan and oversee its refreshment in line with NHS Improvement's published guidance and timeline;
- To work collaboratively with the Resources Committee, ensuring that:
  - resource decisions and capital developments are consistent with the strategic direction of the Trust;
  - projects are affordable and in line with the Trust's financial model and represents good value for money;
  - outline and full business cases are jointly approved; and
  - the Trust complies with NHS Improvement guidance.
- To ensure robust project management structures and governance frameworks are in place for all major strategic developments;
- To oversee and lead the Annual Planning process;
- To scrutinise and challenge project board recommendations with particular regard to the wider interests of the Trust;
- To provide assurance to the Board that established programme and project boards are managing respective projects appropriately, and that project risks are appropriately recorded and mitigated;
- To approve the establishment of strategic programme and project boards and business development groups and hold these to account in relation to agreed milestones and targets, receiving reports as required;
- To agree the development of strategic partnerships and keep under review:
  - the delivery of their agreed objectives; and
  - the contribution of strategic partnerships to the Trust's growth strategy and sustainability.
- To approve business development and marketing strategies for segments of the Trust's business;
- To be responsible for making strategic recommendations to the Board of Directors for final approval.

In addition to the key duties above, the Strategic Development Committee is also responsible for overseeing a number of sub-committees, which focus on specific strategic and commercial objectives.

Work of the Committee in 2016/17

Through its five meetings in 2016/17, the Strategic Development Committee has:

- Overseen progress in relation to the St Pancras Site Redevelopment programme, including the ongoing development of the Outline Business Case;
- Considered the Sustainability and Transformation Plan for North Central London and wider narrative;
- Monitored progress against the key strategic initiatives from the five-year plan;
- Monitored conversion of business development opportunities into new business (i.e. psychological therapy services);
- Reviewed rehabilitation pathways;
- Considered the Islington/Haringey Wellbeing Partnership;
- Monitored progress in relation to the development of an Institute of Mental Health in partnership with University College London; and
- Overseen and led the annual planning process.

4.8.21 Audit and Risk Committee

Members and meeting attendance

The Audit and Risk Committee comprises three non-Executive Directors, including a non-Executive Chair, and met five times in 2016/17.

Senior officers of the Trust who regularly attended the Committee included the Director of Finance, Chief Executive, Director of Nursing and People, Deputy Director of Finance and the Risk and Patient Safety Manager.

Representatives from the Trust's external and internal auditors, along with counter-fraud specialist representation, attended every meeting.

Audit and Risk Committee members and attendance

Members	Meetings attended
Richard Brooman (Committee Chair)	4/4
Kieran Parmar (Committee Chair w/e March 2017)	1/1
Pippa Aitken	5/5
Sue Goss	4/5

The role of the Audit and Risk Committee is to:

- Monitor the integrity of the Trust's financial statements;
- Review internal financial control, internal control and risk management systems;
- Monitor and review the effectiveness of the internal audit function;
- Monitor and review the effectiveness of the external auditor;
- Develop and implement policy on using external auditors to supply non-audit services;
- Report to the Council of Governors any matters where action or improvement is needed and making recommendations as to the steps taken; and
- Review the arrangements for "whistle blowing".

Work of the Committee in 2016/17

The Committee agrees a work plan based on its terms of reference at the beginning of each year, in order to ensure it discharges all its responsibilities.

Some of the key responsibilities are listed below:

- Monitor the systems of governance through regular review of the risk register and Board Assurance Framework to support the delivery of C&I's principal objectives;
- Approve an internal audit plan that assesses a range of overarching governance and internal control systems;
- Consider reports from internal audit, focusing particularly on those giving 'limited assurance' and the implementation of agreed recommendations;
- Review the Annual Report, including Quality Accounts, and financial statements;
- Consider the annual reports of internal audit, and the local counter fraud specialist.

As well as undertaking its key duties, it undertook its annual review of declared Directors' interests and the receipt of gifts and hospitality. Throughout the year, the Committee considered any waivers to Standing Financial Instructions and material losses or special payments. It also undertook its regular annual review of the Trust's Annual Accounts and Annual Report and, with requested amendments, made appropriate approval recommendations to the Board.

During the year, the Committee received presentations on cyber security and the Trust's site security and Business Continuity and Resilience, the arrangements in place to support staff in raising concerns and on information governance. It also oversaw 2nd tier committees covering Information Governance and Health, Safety and Fire. The Committee also obtained assurance as to the performance and independence of the Trust's external auditors, Deloitte.

KPMG provides the key internal audit function to the Trust.

4.8.22 Resources Committee

Committee Membership

The Resources Committee's membership comprises a non-Executive Director Chair, one further non-Executive member; and three Directors - including the Deputy Chief Executive/Chief Operating Officer, the Director of Finance and the Director of Nursing & People. Regular attendees include the Chief Executive and representatives from Finance, Estates & Facilities, Human Resources and ICT.

Meeting attendance

The Committee met six times in 2016/17. Attendance was as follows:

Resources Committee members and attendance

Members	Meetings attended
Angela Harvey (Chair) NED	6/6
Leisha Fullick Trust Chair	6/6
Paul Calaminus Deputy Chief Executive / Chief Operating Officer	5/6
David Wragg Director of Finance	4/6
Claire Johnston Director of Nursing & People	4/5

Role and duties

The role of the Resources Committee is to oversee the strategic planning and management of the Trust's operational resources, including those related to workforce; finance; and information and communications technology (ICT/Digital).

The main duties of the Resources Committee are:

- To recommend to the Board financial objectives that will support Trust objectives;
- To monitor delivery of the statutory and Trust financial objectives and agree appropriate actions;
- Examine financial performance of the Trust including income and expenditure; balance sheet; cash flow against plan; key financial ratios; and advise on remedial action where necessary;
- To provide regular risk assessments against each financial objective, ensuring action plans are developed and implemented, where required, and the risk register updated accordingly;
- To monitor the Trust's borrowing arrangements and agree any actions necessary;
- To scrutinise the assumptions underpinning financial modelling within the Business Plan and advise the Board accordingly;
- To recommend to the Board an appropriate cash management strategy to deliver the agreed Business Plan;
- To agree principles and approach for internal budget setting;
- To approve all bids for additional revenue and capital funding above a limit set in the Trust's Scheme of Delegation and/or with significant business implications;
- To agree principles and approach for substantial or material contracts and be a point of referral in negotiations if required;
- Ensure an Estates Strategy is implemented that supports the Business Plan and meets all legislative duties and national targets;
- To ensure that the estate is utilised effectively and efficiently;
- To approve the annual Capital Programme based on recommendations from the Estates & Capital Planning Group;
- To provide regular risk assessments against Estate Strategy objectives, ensuring action plans are developed and implemented where required and the risk register updated accordingly;

- To oversee the information, communications technology and digital development plans of the Trust;
- To oversee the Trust Digital strategy and monitor compliance, ensuring that this is in line with the Trust's priorities;
- To oversee the activities of the Trust's dedicated Digital Development Committee;
- To oversee the Trust's workforce plans and strategy, including learning and development and mandatory training, and monitor compliance, ensuring that these are in line with the Trust's priorities and values; and
- To oversee the activities of the Trust's dedicated Workforce Committee.

Work of the committee in 2016/17

Through its six meetings in 2016/17, the Resources Committee has:

- Overseen the development of Estates and ICT strategies to support the development of the Trust's St Pancras site;
- Overseen the update of the Trust's Workforce Strategy;
- Given detailed consideration as to where the Trust's workforce currently lives and the options for local recruitment;
- Approved the Trust's Recruitment and Retention Strategy;
- Maintained a keen focus on changes related to the introduction of apprenticeships and the quality of services from the Trust's new occupational health service provider;
- Monitored the Trust's financial plans and financial position, including capital expenditure. The Committee retained a strong focus on Cost Improvement Plans and the more volatile costs related to additional temporary staff and the need for additional external beds;
- Retained a keen eye on ICT developments, particularly in relation to improvements in electronic patient records and e-mail communication with Governors;
- Undertaken its annual consideration of reference costs; and banking, working capital facility and borrowing arrangements;
- Had oversight of the proposed changes to the junior doctors' contract and considered their potential impact on the Trust. Retained an overview on anti-ligature refurbishment works throughout the Trust;
- Considered proposed estates strategies for the North Central London patch and had oversight of property disposal;
- Received updates on the Trust's procurement process;
- Considered the results of the Trust's 2016 Patient Led Assessment of the Clinical Environment (PLACE);
- Monitored the activities of its 2nd tier committees, namely the Workforce Committee; Estates and Capital Planning Committee; and the Digital Development Committee.

4.8.23 Executive Directors' Nominations Committee

Members and meeting attendance

The Executive Directors' Nomination Committee is responsible for the identification and nomination of suitable candidates for Executive Director positions.

The membership of this Committee comprises all the non-Executive Directors and the Chief Executive.

Executive Directors' Nominations Committee members and attendance

Members	Meetings attended
Leisha Fullick (Committee Chair)	2/2
Pippa Aitken	2/2
Richard Brooman	2/2
Tom Burns	1/2
Sue Goss	2/2
Angela Harvey	2/2
Angela McNab	2/2
Patrick Vernon	1/2

During 2016/17, the Committee met on two occasions. Its key focus during the year was to take forward the recruitment of a new Chief Operating Officer. It also considered the overall composition of the Board and the appointment of a new Deputy Trust Chair to replace Mr Richard Brooman when his term of office came to an end in February 2017. The committee maintained a keen focus on ensuring that the Board should reflect the Trust's values, particularly in relation to equality and diversity.

4.8.24 Executive Directors' Remuneration Committee

Members and meeting attendance

Membership for the Remuneration Committee comprises the Trust Chair and two other non-Executive Directors. The committee met three times during 2016/17, including once by telephone.

Executive Directors' Remuneration Committee members and attendance

Members	Meetings attended
Leisha Fullick (Committee Chair)	3/3
Richard Brooman	3/3
Angela Harvey	3/3

The Executive Directors' Remuneration Committee sets pay and terms of service for the Executive Directors and other senior members of the executive management team as the Board may determine. The Committee sets remuneration with due regard to benchmarking information and survey data of other comparative senior posts within the NHS sector. The salary and pension entitlements for the Executive Directors of the Trust are set out later in this publication in the Remuneration Report at section 4.10.

During the year the Committee considered a commissioned report on directors' remuneration, agreed a 1% pay award to executive salaries, in line with the 1% Agenda for Change pay increase applied to staff, and considered necessary matters of redundancy.

4.8.25 Executive Directors' Nominations Committee

In consultation with the Council of Governors, an agreed process is in place to evaluate the performance of the Chair and non-Executive Directors. The Chief Executive carries out regular evaluation of the performance of Executive Directors. The performance of Board committees is subject to annual review and the Board has a yearly Board review and evaluation seminar in June, all of which helps to inform and develop both individual and collective Board development and training needs.

The overall approach that is followed includes:

- The performance of the Chair is evaluated by self-assessment. Each Board Member and the Council of Governors is asked to complete an evaluation questionnaire and rate the performance of the Chair against agreed criteria and performance objectives. This process is facilitated by the Senior Independent Director;
- The performance of each non-Executive Director is evaluated by self-assessment and assessment by the Chair. This is further monitored by the Council of Governors' Nominations and Remuneration Committee.
- The appraisal of the performance of the Executive Directors is carried out by the Chief Executive, who in turn is appraised by the Chair;
- The collective performance of the Board is evaluated by each Board Member and the Board agrees a development plan for the year based on the outcome of this evaluation;
- Personal development plans and objectives are agreed for all Board Members and monitored during the year.

During 2016/17 the following Board seminars considered the following:

- The Trust's culture, agreeing values and how these would be embedded;
- St Pancras redevelopment and potential partners;
- NCL sustainability and transformation work streams;
- CQC improvement work plans;
- Learning disability and section 75 partnership reports;
- Development of a forward view for Trust Board business;
- Asbestos awareness; and
- New guidance related to corporate manslaughter.

Trust Open Day

4.9 Staff report

4.9.1 Analysis of average staff numbers

The tables below show the Trust staff costs and average number of staff employed for 2016/17.

Staff Costs in 2016/17

	Group			
	Permanent	Other	2016/17 Total	2015/16 Total
Salaries and wages	68,423	768	69,191	67,849
Social security costs	7,174	-	7,174	5,534
Employer's contributions to NHS pensions	8,627	-	8,627	8,484
Pension cost - other	-	-	-	-
Other post-employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	-	-	-	-
Temporary staff	-	10,531	10,531	11,412
Total gross staff costs	**84,224**	**11,299**	**95,523**	**93,279**
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	**84,224**	**11,299**	**95,523**	**93,279**
Of which:				
Costs capitalised as part of assets	-	-	-	-

Average Staff in Post 2016/17

	Group			
	Permanent	Other	2016/17 Total	2015/16 Total
Medical and dental	118	-	118	124
Ambulance staff	-	-	-	-
Administration and estates	286	-	286	293
Healthcare assistants and other support staff	364	-	364	314
Nursing, midwifery and health visiting staff	404	-	404	401
Nursing, midwifery and health visiting learners	-	-	-	-
Scientific, therapeutic and technical staff	632	-	632	625
Healthcare science staff	-	-	-	-
Social care staff	5	-	5	4
Agency and contract staff	-	63	63	88
Bank staff	-	160	160	187
Other	-	-	-	-
Total average numbers	**1,809**	**223**	**2,032**	**2,036**
Of which:				
Number of employees (WTE) engaged on capital projects	-	-	-	-

4.9.2 Gender breakdown

The table below shows the number of staff employed by the Trust by Gender as at 31 March 2017. The figures include the 323 Trainee Clinical Psychologists who are hosted on the Trust payroll.

Breakdown of staff by gender

Code	Female	Male	Total Headcount
Executive Director	3	4	7
Non-Executive Director	4	3	7
Senior Manager	5	10	15
Employees	1,394	555	1,949
Grand Total	1,406	572	1,978

4.9.3 Exit packages

The table below shows the exit packages paid during 2016/17, all of which related to pay in lieu of notice.

During the period there was a total of three redundancy payments, three payments in lieu of notice and one non-contractual payment requiring HM Treasury approval.

Reporting of compensation schemes - exit packages 2016/17

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
<£10,000	1	1	2
£10,001 - £25,000	-	3	3
£25,001 - £50,000	1	-	1
£50,001 - £100,000	-	-	-
£100,001 - £150,000	1	-	1
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	**3**	**4**	**7**
Total resource cost (£)	£153,000	£67,000	£220,000

Reporting of compensation schemes - exit packages 2015/16

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
<£10,000	-	6	6
£10,001 - £25,000	-	-	-
£25,001 - £50,000	-	-	-
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	**-**	**6**	**6**
Total resource cost (£)	£0	£23,000	£23,000

The table below shows any other non-compulsory exit packages paid during 2016/17. The only payments made in 2016/17 related to pay in lieu of notice as detailed above.

Exit packages - other (non-compulsory) departure payments

Type	2016/17 Number of payments agreed	2016/17 Total value of payments agreed (£)	2015/16 Number of payments agreed	2015/16 Total value of payments agreed (£)
Voluntary redundancies including early retirement costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	1	£28,000	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	2	£37,000	6	£23,000
Exit payments following Employment Tribunals or court orders			-	-
Non-contractual payments requiring HMT approval	1	£2,000	-	-
Total	**4**	**£67,000**	**6**	**£23,000**
Of which:				
Non contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

4.9.4 Off-payroll engagements

The tables below outline the details of any off-payroll arrangements during 2016/17.

For all off-payroll engagements as of 31 March 2017, for more than £220 per day and that last for longer than 6 months.

Type	Number of engagements
Number of existing engagements as of March 2017	6
Of which	
Number that have existed for less than one year at the time of reporting	1
Number that have existed for between one and two years at the time of reporting	2
Number that have existed for between two and three years at the time of reporting	1
Number that have existed for between three and four years at the time of reporting	2
Number that have existed for four or more years at the time of reporting	-

All off-payroll engagements have been subjected to a risk based assessment

For all new off-payroll engagements, or those that reached 6 months in duration between 1 April 2016 and 31 March 2017, for more than £220 per day and that last for longer than 6 months.

Type	Number of engagements
Number of new engagements, or those that reached six months in duration between 1 April 2016 and 31 March 2017	3
Number of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and national insurance obligations	3
Number of who assurance has been requested	3
Of which	
Number of whom assurance has been received	3
Number for whom assurance has not been received	-
Number that have been terminated as a result of assurance not being received	-

For any off-payroll engagements of Board members, and/or senior officials with significant financial responsibility between 1 April 2016 and 31 March 2017

Type	Number of engagements
Number of off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, during the financial year	-
Number of individuals that have been deemed "Board members and/or senior officials with significant financial responsibility". This figure should include both off-payroll and on-payroll engagements.	7

From January 2017, the Trust implemented a Temporary Staffing Panel with the following criteria:

- From the start of January use of non-Framework agencies is not permitted
- From the start of January the use of agencies that are supplying staff with wage cap breaches will not be permitted
- The use of last minute 24 hour agency bookings will cease from the start of January and local cover arrangements will be managed
- Requests to cover annual leave or secondments will not be accepted. All secondments currently covered by agency should be considered for return to C&I and executive sign-off required to continue
- Long term bookings will be reviewed at eight weeks as they will not be permitted to be longer than 12 weeks, and should be replaced by a fixed term contract or bank via NHSP
- Permission to use long-term agency staff from more expensive agencies due to the specialist nature if clinical will need to be approved by the Director of Nursing or Medical Director
- After two unsuccessful recruitment attempts managers should liaise with their HRBP to cease trying to recruit and work with the division or department to redesign the role or consider a different approach to the recruitment also considering a recruitment and retention premium in certain circumstances if required.
- Use of agency in non-service user facing roles will be reviewed on a case by case basis by the panel
- Use of agency not approved by the panel will be terminated and the manager who authorised the booking will be managed in line with the Trust Disciplinary Policy
- No agency for maternity cover considers bank or a fixed-term contract within budgetary constraints.

From May 2017, the weekly Vacancy Control Panel will take over the monitoring of this process to ensure the reduction of agency usage and encourage of recruitment to vacant posts. If temporary cover is required the panel will make sure that the most cost effective solution is being proposed for longer term temporary staffing cover.

The panel also reviews requests to use contractors to ensure correct and cost effective use, giving the assurance that the NHSI agency caps are adhered. This scrutiny provides assurance to the Trust that every consideration is being taken to reduce Trust agency spend including highly agency paid staff.

4.9.5 Expenditure on consultancy

The Trust reported a total of £384k on consultancy expenditure in 2016/17 compared with £603k in 2015/16.

4.9.6 Staff engagement and communication

Several new approaches to the way the Trust communicates internally – and externally – were introduced during the year.

With the arrival in May of Angela McNab as the Trust's new CEO, new regular briefing updates on significant issues were introduced for senior managers to cascade to their teams.

A new programme of "News and Views" sessions was held every two months, at which a member of the Trust executive team updates on an important theme followed by staff discussion.

Successful meetings in the programme to date have been held on:

- How the Trust can become an outstanding organisation;
- Staff wellbeing; and
- An update on ongoing research at the Trust.

Other significant developments during the year included the launch of the Trust's new strategic aims and supporting cultural pillars; and early engagement around the proposed redevelopment of the Trust's St Pancras site. Both these issues were supported by specific internal briefing programmes.

The CEO also provided updates to staff through regular email announcements and newsletters to staff.

Following the Care Quality Commission inspection report in 2016, a series of internal training programmes and roadshows were run to address some of the areas highlighted as requiring improvement.

A key project during the year continued to be lengthy preparation development work to introduce a new Trust intranet, which was successfully launched in April 2017 alongside a revamped weekly staff bulletin.

Our quarterly newsletter C&I was also redesigned, and moved to a more compact A4 size with an increased focus on service user experience.

We introduced a quarterly, complementary digital bulletin, in between publication of C&I News, for senior, external stakeholders.

Staff have also been encouraged to engage with, and support, the Trust's growing social media presence, for instance by following the Trust's Twitter account @CI_NHS.

During the year the number of followers of the Trust's Twitter account increased by 50% from 800 followers to more than 1,200 by year end.

Staff were again heavily involved in the Trust's annual Open Day, held at St Pancras Gardens in September, with some key services and support activity manning stands to showcase their work, highlight the work of volunteers and recruit new Trust members.

All our local MPs were invited and Islington North MP, Jeremy Corbyn, and Sir Keir Starmer, Holborn and St Pancras MP, both attended.

Staff and service users have presented and attended regular early evening seminars on interesting Trust clinical research or initiatives. These events, previously known as "Medicine for Members", have been re-branded as "Mental Health Matters" during the year to better describe its purpose and draw a wider audience.

Trust staff showcase some of our services at our Annual Members' Meeting 2016

4.9.7 Staff Survey

The Trust is committed to engaging with staff and listening actively to their concerns.

Each year we invite our staff to take part in the annual national Staff Survey, which provides an opportunity for them to give feedback on key aspects of working at the Trust. This helps highlight areas of good practice and also pinpoints where improvements must be made.

The survey gathers views on their experience at work around key areas including development opportunities, health and wellbeing, staff engagement, and opportunity for raising concerns.

C&I Staff Survey 2016 Response Rate

2016 C&I	2015 C&I	2016 National Mental Health/ Learning Disability Trust Average	Trust Improvement/ Deterioration	Ranking compared with all mental health trusts 2016
55.5%	52.0%	49.5%	Increase of 3.5 percentage points	Above average

The Trust's 2016 Staff Survey response rate was 55.5%, an increase of 3.5% from last year and higher than the national average for Mental Health trusts of 49.5%.

Overall staff engagement

The Trust recorded a score of 3.79 (on a scale of 1-5) against a national average of 3.70 for Mental Health Trusts. This is an increase from the 2015 score of 3.70.

The tables below show the top and bottom five ranking scores and how we compared with last year's results, as well as with other Mental Health trusts.

C&I Top Five Ranking Scores 2016

Top five ranking key findings	Trust Score 2015	Trust Score 2016	National 2016 average for mental health	Trust Improvement/ Deterioration	Ranking compared with all mental health trusts 2016
KF7. Percentage of staff able to contribute towards improvements at work - the higher the score the better	74%	78%	73%	Increase of four percentage point	Above (better) than average
KF12. Quality of appraisals	3.29	3.4	3.15	Increase of 0.11 point	Above (better) than average
KF6. Percentage of staff reporting good communication between senior management and staff - the higher the score the better	35%	42%	35%	Increase of seven percentage point	Above (better) than average
KF9. Effective team working - the higher the score the better	3.89	3.84	3.85	Decrease of 0.5 points	Above (better) than average
KF3. Percentage of staff agreeing that their role makes a difference to patients/service users - the higher the score the better	90%	90%	89%	No change	Above (better) than average

The 2016 Staff Survey showed positive results in staff feeling able to contribute towards improvements at work, good communication between senior management and staff, effective teamwork and staff agreeing that their role makes a difference to service users.

The survey also highlighted areas for attention, including staff concern with the lack of equal opportunities for career progression, staff saying that they had experienced discrimination at work in the last 12 months and a low number of staff who had then reported it. These are areas of significant concern and the Trust is working hard to increase support for staff.

C&I Bottom Five Ranking Scores 2016

Bottom five ranking key findings	Trust Score 2015	Trust Score 2016	National 2016 average for mental health	Trust Improvement/ Deterioration	Ranking compared with all mental health trusts 2016
KF20. Percentage of staff experiencing discrimination at work in the last 12 months - the lower the score the better	23%	22%	14%	Decrease of one percentage point	Above(worse than) average
KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months - the lower the score the better	40%	39%	33%	Decrease of one percentage point	Above (worse than) average
KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion - the higher the score the better	77%	76%	87%	Decrease of one percentage point	Below (worse than) average
KF11. Percentage of staff appraised in last 12 months - the higher the score the better	85%	86%	89%	Decrease of one percentage point	Below (worse than) average
KF27. Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse - the higher the score the better	48%	56%	60%	Decrease of eight percentage points	Below (worse than) average

The Trust continues to work on the key themes raised in last year's report, relating to equality and diversity, health and safety and raising concerns. It continues to build on the successes to date, such as the substantial overhaul of our approach to raising and supporting the BME Staff Network group. Separately, the Equality and Diversity Staff Network has been set up for staff to meet, share experiences, receive training, but also to be involved in making organisational changes.

The Trust also has a "Safecall" facility for staff to use to raise any concerns and during the year recruited a Freedom to Speak Up Guardian. Their role is to help raise awareness about voicing concerns at work and provide confidential advice and support to staff in relation to concerns they may have about patient safety.

The Trust is engaged in significantly increasing the proportion of BME staff at bands 8a to 9. It is also developing a training and development programme, specifically targeting BME staff at bands 5 to 7 to support their progression in the Trust. This will foster a more inclusive and positive culture within the Trust

Non-Executive Director, Patrick Vernon, discusses race equality at a Mental Health Matters event

During the year, the Trust launched "Our Staff First" - a commitment to investing in our staff and retaining talent. The Trust's vision is to attract highly skilled staff and for our existing staff to have a long and rewarding career within it.

"Our Staff First" initiatives include:

- Career Clinics - The Human Resources (HR) and Organisational Development (OD) Team are running monthly peripatetic career clinics across all sites, giving staff the opportunity to informally discuss internal development or career opportunities. The aim of these clinics is to retain our existing staff and support their professional development where possible.
- Themed HR & OD roadshows are running on a regular basis offering staff the opportunity to seek advice and information on specific hot topics such as working flexibly, bullying and harassment, and coaching and mentoring
- Internal promotion by putting our staff first, advertising our Band 5 and above vacancies internally for two weeks, before recruiting from an external pool, as well as encouraging and supporting our staff in applying for internal vacancies by offering them interview skills training.

The Trust recognises that there is still more work to be done to support staff, ensuring the development and implementation of a response plan that prioritises those key areas in which improvements need to be made. The Trust's commitment to actively engaging in "Our Staff First" and recruitment and retention can also be seen in our approach to responding to the staff survey results of 2016. At a local level, our clinical divisions have had sight of their data and will be drafting local action plans to address their local issues of concern.

4.9.8 Improving staff experience

A wide range of activities and initiatives was introduced in 2016/17 to support the health and wellbeing of staff, building on the progress of the previous year and measured by a specific Health and Wellbeing CQUIN.

Following feedback from staff requesting physical activity sessions, yoga, Zumba and netball sessions were organised, alongside salsa and table tennis events as part of the Greater London Authority's Healthy Living Week in September.

In February 2017, in collaboration with the Trust's facilities management contractor Engie, 180 staff attended two Healthier You Workshops where they took part in physical activity and signed up for basic health checks.

The Trust has also run a successful programme of stress management courses, including mindfulness-based Cognitive Behavioural Therapy and resilience sessions. It has also been working with an NHS partner to establish fast track physiotherapy for staff.

During the year, at the request of the Trust, a new healthy food policy was introduced at staff restaurants at the St Pancras and Highgate sites.

All food and drink high in fat, salt, sugar and saturates (HFSS) was removed from checkout points, and discounts and advertisements for such food were ended. Other measures included introducing a larger range of fresh fruit at St Pancras.

For 2017/18 specific targets have been set which included reducing the availability of drinks with high sugar content.

During the winter of 2016/17, the Trust introduced an intensive campaign to encourage staff to have the flu vaccination, in line with the Department of Health's take-up target of 75%.

The campaign resulted in 506 vaccines being given to frontline staff, achieving a 36.8% vaccination rate in total, compared with 480 the year before.

The steering group will be looking at ways to further increase this figure for the next campaign.

4.9.9 Sickness absence data

Sickness absence data is published quarterly in the Human Resources performance reports received by the Board, as well as presented at the monthly divisional performance meetings.

The table below shows the sickness absence data for the period January - December 2016 (as per NHS Improvement guidance).

Sickness Absence
January 2016 – December 2016

Source: from ESR

**FTE - Full Time Equivalent*

	Average FTE* 2016	Adjusted FTE sick days	FTE days available	FTE days recorded sickness absence	Average annual sick days per FTE
Data January - December 2016	1,841	13,060	671,921	21,185	7.1

4.9.10 Health and safety performance

There has been significant activity relating to health and safety (H&S) related matters within the Trust during the year.

The major part of the Trust's physical anti-ligature programme across inpatient and residential sites was undertaken and completed in 2015/16 and the early part of 2016/17.

Further work has been undertaken around anti-ligature measures and general patient safety arising from the CQC inspection in February 2016. Ligature risk assessments are carried out on a six-monthly basis in all inpatient and residential facilities and these continue to refine our learning.

They also provide a process for continuous assessment of risks based on operational management of the environment and the specific risk of group or individual service users. The ligature risk policy has been reviewed and updated and additional training of Trust staff and our total facilities management contractor maintenance staff undertaken.

A major H&S incident for the Trust was a fire that took place in Sapphire Ward, Highgate Mental Health Centre, in May 2016. This was caused by service user arson and, as a result, half of the ward was out of action for several months whilst physical damage to the bedroom and smoke damage to the female section of the ward was repaired.

As a result of the fire, the London Fire and Emergency Planning Authority (LFEPA) served an enforcement notice on the Trust requiring us to take various actions to reduce fire risks. A key requirement was the installation of mechanical bedroom door closers that ensure that the default position for the doors is closed. Other requirements of the notice related to improved fire awareness training of permanent and agency staff, review of no smoking and search policies and maintenance of fire safety systems. All these matters were dealt with to the satisfaction of the LFEPA and the notice was lifted in March 2017.

Following the discovery of asbestos containing materials (ACMs) in the boiler house and service tunnels at St Pancras Hospital in August 2015, we have continued to manage these issues through the Trust's asbestos policy, management plan and register.

The boiler house and key plant rooms at St Pancras are now 'asbestos safe' enabling proper management of the services and the majority of building controls. ACMs remain in some of the site service tunnels and some building undercrofts, but access to these areas is not generally required and is restricted.

Condition of plant in these areas will be monitored through periodic video inspections and licensed contractors employed to undertake works if appropriate. It would be expensive or difficult to remove these ACMs and the most appropriate time to undertake this is when the site is partially or wholly vacated as part of the site demolition and redevelopment.

As part of protecting its staff, service users and visitors from crime, particularly violence and aggression, the Trust has appointed a full-time Local Security Management Specialist. This is line with guidance from NHS Protect and indicates the Trust's full support for its principles of protecting NHS staff from injury and ensuring NHS assets are securely maintained.

4.9.11 Occupational health

The Occupational Health Service (OHS) is provided by People Asset Management (PAM), the first year of a three-year contract to provide such services to the Trust.

The OHS is delivered from the Bloomsbury Building at St Pancras Hospital; however Trust employees can be seen at other PAM Clinics within the London area. The OHS provides a range of activities which are aimed at promoting and supporting the health and wellbeing of the Trust's employees and supporting managers in achieving the safe and timely return of employees to the workplace following sickness absence.

The specific activities include on-employment health screening, immunisation and vaccination services, health surveillance, management referral, workplace assessments, psychological support, and health education and promotion. In addition, PAM's Employee Assistance Programme (PAM Assist) is available to all employees 24/7, 365 days a year.

The service is managed through regular service review meetings to ensure compliance with contract requirements and PAM undertakes monthly internal audit to ensure our staff provide a professional, quality and timely service.

Management information compiled throughout the first year of service provision has shown that the top two reasons for referral to OH are mental health and musculoskeletal health conditions. Identifying these conditions will allow a targeted and planned approach to our overall health and wellbeing programme.

4.9.12 Countering fraud and bribery

The Trust takes its responsibilities to minimise fraud with the utmost seriousness, and ensures that all reasonable measures to counter fraud and bribery are taken where concerns are raised.

The Trust has an established and embedded counter fraud policy and a named local counter fraud specialist, who is able to investigate all suspicions and allegations of fraud in a confidential manner, and who also undertakes reactive investigations and continues to publicise the impact of fraud and bribery on the NHS in accordance with Secretary of State Instructions.

4.9.13 Our commitment to ensuring equality and diversity

We are wholly committed to ensuring equality and diversity in the workforce. Our staff demographics and operation of our HR policies in the context of equality is monitored and details provided to the Board.

The Equality Delivery System (EDS) is a system that helps NHS organisations to improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, whilst meeting the requirements of the Equality Act 2010. The EDS was developed by the NHS, for the NHS, taking inspiration from existing work and good practice. A refreshed EDS – known as EDS2 – was made available in November 2013 and has been adopted by the Trust in order to identify, implement, embed and deliver its Equality and Diversity Strategy and Action Plan. The Trust's Equality and Diversity Committee oversees its successful implementation.

In addition, the Trust adopted the Workforce Race Equality Standard (WRES) in 2015 which requires collation of workforce ethnicity data to be published on our website annually.

The Trust's policy is that everyone who works, or applies to work, in the Trust is treated fairly and valued equally. The Trust is committed to a fair and equitable recruitment process, which is supported by the Recruitment and Retention Strategy.

Our aim is to attract highly-skilled staff and for our existing staff to have long and rewarding careers with the Trust. All Trust vacancies are advertised with clear reference to our values and a clear job description and person specification, which are drafted to ensure that we recruit based on the skills, competency, values and experience required for the post.

All roles are graded according to the national framework, which is designed to ensure equity between similar posts. In light of our commitment to enhancing equality and diversity, we have developed "Our Staff First" Strategy which aims to address BME staff in to senior positions, career development opportunities and a range of other initiatives.

Vacancies are advertised publicly on the national website for NHS jobs and promoted internally via the Trust Intranet. We have also taken the opportunity to advertise our NHS jobs on dedicated BME websites in order to encourage under-represented groups to apply for vacancies and promote C&I as an employer of choice. Equality monitoring on all applications is promoted within the Trust and our electronic system automatically conceals all personal information about applicants as it arrives. Candidates are shortlisted solely on the merits of the written application.

The Trust is a 'Two Ticks' Disability Symbol User, which means we are positive about employing disabled people. As a result, we demonstrate the following commitments:

- To interview all applicants with a disability who meet the minimum criteria for a job vacancy and to consider them on their abilities;
- To ensure there is a mechanism in place to discuss with disabled employees what can be done to make sure they can develop and use their abilities;
- To make every effort when employees become disabled to ensure they stay in employment;
- To take action to ensure that key employees develop the appropriate level of disability awareness needed to make these commitments work.

Reasonable adjustments are made during the interview stage if applicants have a disability or require additional support.

4.9.14 Guidance and oversight in relation to mental health law

The Mental Health Law Committee has oversight and scrutiny of all issues relating to mental health law relevant to the services and duties delivered by the Trust and its local authority partners.

This is to help improve risk management and service user experience and provide assurance to the Board, governors and Trust partners, on the appropriate and effective administration and application of mental health law in practice and adherence to best practice guidance throughout the Trust.

The committee comprises internal and external legal expertise, associate divisional directors as well as the Head of Social Care and Social Work, service user and carer representatives.

During 2016/17, it has promoted all aspects of how the Trust implements the Mental Health Act (MHA) and Mental Capacity Act (MCA) ensuring that mental health law is included as a core training topic, making it a mandatory requirement, for all clinical staff.

4.10 Remuneration report

We are pleased to present the Senior Managers' Remuneration Report for 2016/2017, prepared in conjunction with the Hutton Review of Fair Pay and the NHS Foundation Trust Annual Reporting Manual.

The remuneration of the Chief Executive and other Executive Directors on the Board of Directors is determined on an annual basis by the Remuneration Committee (a sub-committee of the Board of Directors). The remuneration of the Chair of the Trust and the other Non-Executive Directors (NEDs) is determined on an annual basis by the Council of Governors' Remuneration Committee.

4.10.1 Remuneration Committee (Board of Directors)

The Remuneration Committee consists of three NEDs. During the year under review the Committee members were Leisha Fullick (Trust Chair), Angela Harvey and Richard Brooman. Attendance at meetings is detailed over:

Remuneration Committee (Board of Directors) members and attendance

Members	Meetings attended
Leisha Fullick (Committee Chair)	5/5
Richard Brooman	5/5
Angela Harvey	5/5

4.10.2 Chair of the Remuneration Committee's report

All Executive Directors are employed on a permanent senior manager's contract which has a minimum notice period of six months. Executive Directors' salaries are not included within the scope of the NHS national pay and grading system known as Agenda for Change which all other Camden & Islington employees are subject to.

All decisions on Executive Directors' remuneration are wholly within the remit of the non-Executive Directors who comprise the Committee. No Executive Directors or senior managers receive performance related bonuses. Termination payments are only made in accordance with individual contracts of employment.

The Executive Director Remuneration Policy applies to all executive directors (including the Chief Executive) and other non-voting director members of the Board.

This policy is concerned with setting the levels of remuneration only. Other terms and conditions of service for executive directors, non-voting board members and other senior managers, are as per the standard NHS Agenda for Change contracts, which includes arrangements for loss of office. The Committee has not formally consulted with employees in relation to the Director Remuneration Policy.

The Board of Directors' Remuneration Committee will take into consideration relevant nationally determined parameters on pay, pensions and compensation payments.

The Committee reviews director remuneration annually taking into consideration national pay awards and sensitivities, including executive pay relative to their direct reports.

The Board of Directors' Remuneration Committee commissioned the Hay Group to undertake a benchmarking review of remuneration for the Executive Directors. The Committee met on 27 June 2016 to consider this review and concluded that the Foundation Trust is paying its Executive Directors at levels very similar to those of its comparators. For 2016/17, the Committee awarded the Executive Directors a 1% pay uplift backdated to 1 April 2016.

There were several changes to the board during 2016/17. Ms McNab joined the Trust in late April 2016, Mr Calaminus left the Trust at the end of February 2017 and Ms Johnston was seconded in February 2017 to work on the NCL Strategic Transformation Plan.

4.10.3 Non-Executive Directors

Leisha Fullick, Angela Harvey, Susan Goss, Pippa Aitken, and Patrick Vernon were all in post for the full year. Richard Brooman's term ended during the year and we were joined by Professor Tom Burns and Kieran Parmar.

The Governors' Nominations and Remuneration Committee met on 6 April 2016 where they agreed that the Chair and NEDs should receive a 1% pay increase for 2016/17 in line with the agenda for change increase for other staff. This was subsequently approved by the full Council on 10 May 2017.

4.10.4 All Other Senior Managers

There have been no payments to third parties for services of a Senior Manager. None of the Trust's other Executive Directors currently serves as a non-Executive Director for any other organisation. The following tables show the disclosures of salaries and allowances for senior staff during 2016/2017, and are subject to audit. There were no payments to past senior managers.

4.10.5 Salaries and allowances

Director Summary

Name & Title	2016/2017			2015/2016		
	Salary Bands of £5,000 £000	**Pension related benefits** Bands of £2,500 £000	**Total** Bands of £5,000 £000	**Salary** Bands of £5,000 £000	**Pension related benefits** Bands of £2,500 £000	**Total** Bands of £5,000 £000
Ms Angela McNab* *Chief Executive*	150-155	0	150-155	0	0	0
Mr Paul Calaminus** *Chief Operating Officer/Deputy CEO*	100-105	30-32.5	130-135	105-110	37.5-40	145-150
Mr David Wragg *Director of Finance*	115-120	12.5-15	125-130	115-120	15-17.5	130-135
Ms Claire Johnston *Director of Nursing & People*	95-100	65-67.5	160-165	100-105	2.5-5	105-110
Dr Vincent Kirchner*** *Medical Director*	155-160	40-42.5	195-200	155-160	n/a	155-160

Notes

There were no Taxable Benefits, Annual related Performance or Long Term Performance Related Bonuses paid during the period.

* There are no prior year comparatives for Ms McNab as she joined the Trust in April 2016.

** Mr Calaminus left the Trust at the end of February 2017.

*** Dr Kirchner's renumeration is split between his duties as an Executive Director and as a consultant, with consultant salary between the band of 95-100.

4.10.6 Pension Benefits

Pension Benefits

Name & Title	Real increase in pension at age 60 (bands of £2,500) £000	Lump sum at aged 60 related to real increase in pension (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2017 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2016 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2017 £000	Cash Equivalent Transfer Value at 31 March 2016 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £000
Ms Angela McNab* *Chief Executive*	0	0	20-25	0	343	0	0	22
Mr Paul Calaminus *Chief Operating Officer/ Deputy CEO*	0-2.5	0-2.5	25-30	70-75	398	377	13	15
Mr David Wragg *Director of Finance*	0-2.5	2.5-5	40-45	120-125	792	728	47	17
Ms Claire Johnston** *Director of Nursing & People*	0-2.5	10-12.5	35-40	110-115	n/a	n/a	n/a	14
Dr Vincent Kirchner *Medical Director*	2.5	0-2.5	60-65	110-115	888	842	27	23

Notes

* There are no prior year comparatives for Ms McNab as she joined the Trust in 2016.

** CETV values are only applicable when under normal retirement age; Ms Johnston has now reached normal retirement age.

4.10.7 NED Salary Summary

NED Salary Summary

Name & Title	2016/2017			2015/2016		
	Salary Bands of £5,000 £000	**Other Remuneration Bands** of £5,000 £000	**Benefits in kind** Rounded £000 £000	**Salary Bands** of £5,000 £000	**Other Remuneration Bands** of £5,000 £000	**Benefits in kind** Rounded £000 £000
Leisha Fullick *Trust Chair*	40-45	0	0	35-40	0	0
Richard Brooman** *Non-Executive Director /* *Chair of Audit & Risk Committee*	10-15	0	0	10-15	0	0
Kieran Parmar* *Non-Executive Director /* *Senior Independent Director*	0-5	0	0	n/a	n/a	n/a
Angela Harvey *Non-Executive Director*	15-20	0	0	10-15	0	0
Dr Sue Goss *Non-Executive Director*	10-15	0	0	10-15	0	0
Pippa Aiken *Non-Executive Director*	10-15	0	0	10-15	0	0
Patrick Vernon OBE *Non-Executive Director*	10-15	0	0	0-5	n/a	n/a
Tom Burns** *Non-Executive Director*	0-5	0	0	n/a	n/a	n/a

Notes
* Mr Brooman's term ended in February 2017
** There are no prior year comparatives for Tom Burns and Kieran Parmar as their terms began during 2016/17.

4.10.8 Current NED Service contracts

Current NED Service contracts

Name	Role	Current term and expiry	Notice period
Leisha Fullick	Trust Chair	31/08/19 2nd Term	3 months
Kieran Parmar	Non-Executive Director/Chair of Audit & Risk Committee	29/02/20 1st Term	3 months
Angela Harvey	Non-Executive Director	31/08/19 1st Term	3 months
Sue Goss	Non-Executive Director	31/05/18 2nd Term	3 months
Pippa Aitken	Non-Executive Director	30/04/18 1st Term	3 months
Patrick Vernon	Non-Executive Director	04/10/18 1st Term	3 months
Tom Burns	Non-Executive Director	02/10/19 1st Term	3 months

4.10.9 Fair Pay Multiple

Fair Pay Multiple

Band of Highest Paid Director's Total	160-165	145-150
Median Total	£32,833	32,508
Remuneration Ratio	4.9	4.5

The Trust is obliged to disclose the median remuneration as a ratio of the mid-point of the banded remuneration of the Trust's highest paid Director to the median full-time equivalent staff of the Trust, in accordance with the Fair Pay Disclosure requirement.

The Trust's highest remunerated Director is the Chief Executive at £161k. Ms McNab's paid salary for 2016/2017 was lower due to Ms McNab's late April 2016 start date. The Trust's median staff remuneration is £33k. Therefore the ratio of Trust's median staff remuneration to the Chief Executive's remuneration is 4.92:1.

The Remuneration Committee has set the Chief Executive's remuneration based on a detailed examination of market rates and the remuneration of other Chief Executives, and considers this to be reasonable.

There has been no significant change in the Trust's workforce during the year; all staff as part of Agenda for Change received a 1% uplift.

Executive Directors are the highest paid staff group within the Trust, no new directors received a higher salary than the previous post holder during 2016-17.

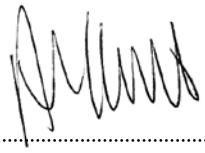
4.10.10 Governors

The Council comprises 25 Governors.

4.10.11 Director and governor expenses

No taxable expenses were paid to any executive or non-executive director during the reporting period.

Three governors received expenses totalling £37.15.



Angela McNab
Chief Executive
26 May 2017

Directors and Governors are required to register with the Trust any conflicts of interest which may conflict with their management responsibilities. Access to these registers is open to inspection by members of the public through the Trust's website, www.candi.nhs.uk.

4.11 Statement of the chief executive's responsibilities as the accounting officer of Camden and Islington NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

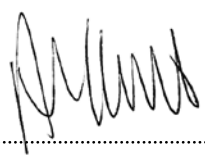
NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Camden and Islington NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Camden and Islington NHS Foundation Trust, and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- Prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above-mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum*.



Angela McNab
Chief Executive
26 May 2017

4.12 Annual governance statement

4.12.1 Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

4.12.2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Camden and Islington NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Camden and Islington NHS Foundation Trust for the year ended 31 March 2017 and up to the date of approval of the annual report and accounts.

The system of internal control, as reviewed by Internal Audit, provides assurance that the Trust is using its resources efficiently, effectively and economically.

The Trust's internal auditors completed their 2016/17 audit programme on schedule, and were able to offer an overall opinion of 'Significant Assurance with Minor Improvements', and only raised a total of three high risk recommendations relating to i) ensuring there are mechanisms for approving breaches of NHS Improvement price ceilings, ii) ensuring approvals were obtained for agency bookings made directly with the agency, and iii) ensuring risks on the Trust Risk Register are reviewed where the residual risk exceeds the target risk. The Audit and Risk Committee is tasked with monitoring progress against all audit recommendations.

4.12.3 Capacity to handle risk

The Trust has in place a Risk Management Strategy that has been approved by the Board and is regularly reviewed. The Risk Management Strategy defines the Trust's approach to, and appetite for, risk and risk management, describes the structures and processes for managing risk and sets objectives against which progress can be measured.

All staff have an introduction to risk and risk management as part of induction; this covers the practical day-to-day responsibilities for all staff, such as incident reporting. A copy of the strategy is available on the Trust intranet and website.

As Chief Executive, I have overall responsibility for risk management across the Trust. I exercise this responsibility through the Board review of the Trust risk register and Board Assurance Framework, designation of Board members with specific accountability and my attendance at the Audit and Risk Committee.

As a key sub-committee of the Board, the Audit and Risk Committee is responsible for scrutinising the Risk Register and Board Assurance Framework, in order that the Board may place reliance on it. The membership of the Audit and Risk Committee is limited to non-Executive Directors, with Executive Directors (including the Chief Executive and Director of Finance) in attendance.

The Trust learns from good practice, through clinical supervision and reflective practice, individual and peer reviews, performance management, various mechanisms to receive feedback from service users and carers, continuing professional development, clinical audit and from serious incident and complaint investigations.

The Trust's Risk Management Annual Report is presented to the Audit and Risk Committee and received by the Board each year.

This report includes consideration of the Trust's major risks and of any future risks that may arise.

In July 2016, the Trust's Annual Risk Management Report 2015/16 gave a comprehensive account of management activities that had been undertaken and those areas requiring continuing focus, including:

- Extensive work to improve falls management, with a 15% reduction in falls in the 24 hour bedded settings compared with the year before
- A significant reduction in the number of AWOL incidents, supported by work undertaken by the AWOL Working Group

During 2016/17, as a result of learnings in the previous year, there has been a continuing focus on strengthening of processes around complaints and incidents management and more effective responding to formal complaints, as well as sharing of knowledge and practice throughout the Trust.

4.12.4 The risk and control framework

The Board regularly reviews its committee structures and puts in place a committee structure that enables the Board itself to spend a significant proportion of its time on strategic decision-making but also ensures proper assurance is obtained and that decisions across the organisation have been made based on the correct information, and in accordance with the reserved and delegated powers agreed by the Board. The Board annually reviews the effectiveness of the system of internal control, has an annual seminar on risk, and receives a Risk Management Annual Report.

The Board publishes an updated Board sub-Committee Handbook on the Trust website. This handbook contains information about all the standing committees of the Board, their terms of reference and meeting dates for the year ahead. In addition to this, the Board also publishes a summary document which sets out the Trust's corporate governance framework. This includes a detailed section on the role and responsibilities of the Board of Directors. Both of these corporate governance documents are available on the Trust's website: www.candi.nhs.uk/about-us/corporate-information/corporate-governance.

Further information about the responsibilities of Directors and Board sub-Committees is provided in the 'Our Governance' section of the report.

Public stakeholders are aware of the Trust's risks as they impact on them and work with the Trust to manage these.

4.12.5 Well-led governance review

During 2015, the Trust undertook the independent Well-led governance review, as required by NHS Improvement (formally Monitor). The agreed approach was to complete a self-assessment based on guidance at the time from Monitor and then subject this self-assessment to scrutiny by independent reviewers. KPMG was appointed to undertake this work.

With regard to compliance with the Trust's provider licence, the Board received a detailed assurance report in May 2015. Specifically, in relation to Foundation Trust Governance (FT4), the Board was satisfied that the Trust fully complied with this licence condition and did not identify any principal risks to compliance.

Such reviews are required every three years and the Trust will therefore be undertaking its next review in 2018.

The Trust was, and remains, satisfied that the Trust is compliant with all licence conditions leading to a valid Corporate Governance Statement.

4.12.6 Care Quality Commission

CQC inspection

The Care Quality Commission (CQC) inspected the Trust in February 2016 and produced its report in June 2016. Overall it rated the Trust as "requiring improvement".

CQC Inspection

Overall rating for services at this Provider	Requires improvement
Are Mental Health Services safe?	Requires improvement
Are Mental Health Services effective?	Requires improvement
Are Mental Health Services caring?	Good
Are Mental Health Services responsive?	Requires improvement
Are Mental Health Services well-led?	Requires improvement

The inspection report rated mental health crisis services and health-based places of safety as Inadequate. Wards for older people with mental health problems, community-based mental health services for older people, and community mental health services for people with a learning disability or autism were rated as Good overall

It highlighted a number of areas of good practice, with a rating of 'good' across the board for older people's community services and inpatient wards and an 'outstanding' for caring. It also rated our staff, Trust-wide, 'Good' for caring, with the inspectors describing them as "responsive and respectful" and willing to go "the extra mile". However, the inspectors also concluded that a number of areas required improvement.

In particular the CQC had concerns over our mental health crisis services and health-based places of safety. It also raised concerns about environment, record-keeping, the environment and some aspects of staff training. And it noted that some service users were experiencing lengthy waits for some psychological therapies.

This is being addressed as part of a top priority action plan. Over the last two years, we have invested more than £4 million in a major estates programme to make environments safer and remove ligature risks. Where this is not possible, due to the age and structure of very old buildings, further training is underway to ensure all staff are able to identify, assess, monitor and deal with ligature risks. We have in partnership with local hospitals made improvements to health-based places of safety and further work is planned. Waiting times for psychological therapies have already improved as a result of placing many of our mental healthcare teams within GP practices, moving the focus away from hospital-based care and so improving access.

4.12.7 Energy efficiency

Procurement of the Trust's energy supplies continues through the Cabinet Office's Crown Commercial Service and has continued to yield significant financial savings over the past 12 months. We are obtaining best possible tariffs through this method of public sector wholesale purchasing and this will continue into the future.

At St Pancras Hospital, the Trust's HQ and largest site, we have previously installed energy monitoring equipment for key buildings. Further electrical surveys have given a better picture of energy use across the site and further monitoring equipment is to be installed into key parts of the utility services to maximise savings, analyse cost and check consumption and billing.

The Trust will commission a Sustainable Development Management Plan in 2017-18 to ensure greater focus on environmental impact going forward.

4.12.8 Review of economy, efficiency and effectiveness of the use of resources

The Trust constantly reviews how it uses its resources, in particular around its cost improvement programmes and service developments. The Board of Directors and the Resources Committee receive regular reports on different aspects of the use of resources (including workforce, finance, estates, and Information and Communications Technology). Specific pieces of internal audit work are commissioned as and when the organisation deems it necessary.

The Trust has used its business planning process and performance management framework as well as established approaches to monitoring progress on the delivery and achievements of its principal objectives and key performance measures in relation to the efficient and effective use of Trust resources.

In particular, the Board of Directors and the Resources Committee monitors the monthly financial position against the Trust's financial plan. Assurance is gained from the positive financial position (as shown in the summary financial statements included in this report), as well as inclusion in segment 2 of NHS Improvement's Single Oversight Framework. Both of these are seen as positive indicators of achieving value for money.

The Trust manages its resources in line with the 'Managing Public Money Standards' and the principles of honesty, impartiality, openness and transparency, accountability, accuracy, fairness, integrity, objectivity and reliability carried out in the spirit of, as well as to the letter of, the law in the public interest to high ethical standards achieving value for money.

4.12.9 Information Governance

Please refer to the update earlier in 4.4 on page 44.

4.12.10 Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

Quality Reports aim to increase public accountability and drive quality improvement within NHS organisations. They do this by getting organisations to review their performance over the previous year, identify areas for improvement and publish that information, along with a commitment about how those improvements will be made and monitored over the next year.

The safety and quality of the care we deliver at Camden and Islington NHS Foundation Trust is our utmost priority. To help us deliver high quality services, we focus on three areas:

- Patient safety
- How well the care provided works (clinical effectiveness)
- How patients experience the care they receive (patient experience).

The Trust's Annual Quality Report, which is the next section of this overall Trust Annual Report, summarises how well we did against the quality priorities and goals we set ourselves for the last year and if we have not achieved what we set out to do, we have explained why and what we are going to do to make improvements. It also sets out the priorities we have agreed for the 2017/18 year and how we intend to achieve them and track progress throughout the year.

One of the most important parts of reviewing quality and setting quality priorities is to seek the views of our service users, staff and key stakeholders. This year we carried out a survey of all those involved with the Trust to discover what their concerns were. From this we drew up a long list of priorities which we put to a public vote. Our nine quality priorities for 2017-18 are the final result of this process.

The Quality Report also includes statements of assurance relating to the quality of services and describes how we review them, including information and data quality. It also includes a description of audits we have undertaken, our research work, how our staff contributes to quality and comments from our external stakeholders.

In addition to complying with the Quality Accounts Regulations, NHS foundation trusts are required to follow the guidance set out by NHS Improvement, which includes reporting on a number of national targets set each year by the Department of Health. Through this Quality Account, we aim to show how we have performed against these national targets. We also report on a number of locally set targets and describe how we intend to improve the quality and safety of our services.

4.12.11 Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation Trust who have responsibility for the development and maintenance of the internal control framework.

I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit and risk committee and quality committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

In addition, my review is informed by the following assessments:

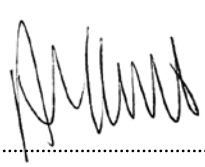
- A full Care Quality Commission inspection in February 2016 and the action plans from that inspection; and
- Assurances resulting from the reports of Internal and External Audit, including the Head of Internal Audit Opinion.

The Audit and Risk Committee provides the Board with an independent and objective review of the systems in place for internal control and risk management and ensures that the Board is kept fully informed of all significant risks and their management. It ensures that the Internal Audit work plan reflects the principal objectives and risks facing the organisation and is delivered in accordance with mandatory auditing standards across our quality, financial and performance systems.

A review of the Trust's arrangements for risk management and internal control has been carried out in accordance with guidance from the Department of Health and Internal Audit Practitioners Group. Internal Audit concluded that all necessary processes (including an Assurance Framework) were in place and operating to provide me with the necessary assurance for the 2016/17 Annual Governance Statement and provide assurance that there is an effective system of internal control to manage the principal risks identified by the organisation. The Head of Internal Audit's opinion was that, for the identified principal risks covered by internal audit work, the Board has substantial assurance.

4.12.12 Conclusion

In summary, the Trust has not identified any significant internal control issues within 2016/17, and has a sound system of internal control and governance in place, which is designed to manage the key organisational objectives and minimise the Trust's exposure to risk. The Board of Directors is committed to continuous improvement and enhancement of the systems of internal control.



Angela McNab
Chief Executive
26 May 2017

5 Quality Account

Part 1
Statement on quality from the Chief Executive

It is my pleasure to present the Quality Account for 2016/17. This has been a busy and important year for us at Camden and Islington NHS Foundation Trust, following the Care Quality Commission inspection report in June 2016, the ongoing development of our Clinical Strategy and the launch early this year of our new strategic priorities. To help us address our challenges our overarching strategic priorities put our future focus on what we think we are good at and how we will develop in the future: early and effective intervention; helping people to live well; and research and innovation.

> These accounts represent our commitment to ensuring that we continue to improve service user and carer experience.

For 2016/17 we set ourselves 12 quality priorities relating to the standard of care for our service users, spanning the three areas of patient safety, patient experience and clinical effectiveness. These reflected a combination of: required improvements in areas of concern highlighted in our Care Quality Commission inspection report; NICE-prescribed guidance; local health priorities or CQUINs (Commissioning for Quality and Innovation).

I am very pleased that with regard to patient experience, we made great progress.

This included involving service users and carers in the implementation of our Clinical Strategy, continuing their strong input to something they had helped co-produce; and tightening up bed management and monitoring to reduce non-clinical ward transfers. Improving the information given to service users about their medication is an area we will continue to focus on.

With regard to patient safety we also made good progress in addressing the national issue of domestic violence. This was through relevant training and awareness-raising amongst staff. However, we were not quite as successful in ensuring violent and aggressive behaviour towards staff was reduced. This is a continuing concern which we need to work further on.

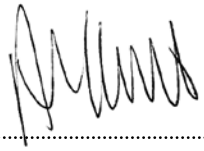
During the year, we have been tightening up our procedures for reviewing mortality and morbidity, and our monitoring of serious incidents involving service users. We appointed a Trust lead on mortality and set up a Mortality Review Group, and we also introduced more effective ways of sharing recommendations and learning from serious incidents. There will be further work in both these areas to review our processes, data and reporting.

We continue to make progress on a number of key priorities relating to clinical effectiveness. I am very pleased that our approach to improving the physical health of our service users who have psychosis has been successfully developed and is bringing clear benefits. We also focused on increasing the numbers of service users who reduce or quit smoking and this will also be a key activity for the Trust. Ensuring the physical and mental wellbeing of all our service users continues to be a priority for the Trust.

In addition, we significantly improved our referral times to comply with the national guidelines for Early Intervention Services (EIS) and IAPT (Improving Access to Psychological Therapies). Activity to enhance staff training and awareness, included improving understanding across the Trust of the Mental Capacity Act (MCA). The inconsistent level of understanding amongst staff was highlighted in the CQC inspection and we will continue work in this area in the current year to ensure improvements are fully embedded.

These accounts represent our commitment to ensuring that we continue to improve service user and carer experience, and to strengthening recovery-focused care and continuous quality improvement. We have made good progress and believe the quality priorities we have selected for this year will help us achieve our ambition to provide outstanding care for every service user.

I declare that to the best of my knowledge the information in this document is accurate.



Angela McNab
Chief Executive
26 May 2017

5.1 Introduction

What is a Quality Report?

All providers of NHS services in England have a statutory duty to produce an annual report to the public about the quality of services they deliver. This is called the Quality Report. Quality Reports aim to increase public accountability and drive quality improvement within NHS organisations. They do this by getting organisations to review their performance over the previous year, identify areas for improvement and publish that information, along with a commitment to you about how those improvements will be made and monitored over the next year.

The safety and quality of the care we deliver at Camden and Islington NHS Foundation Trust is our utmost priority. Here we focus on three areas that help us to deliver high quality services:

- Patient safety
- How well the care provided works (clinical effectiveness)
- How patients experience the care they receive (patient experience).

5.2 Scope and structure of the Quality Report

This report summarises how well we did against the quality priorities and goals we set ourselves for the last year and if we have not achieved what we set out to do, we have explained why and what we are going to do to make improvements. It also sets out the priorities we have agreed for the coming year and how we intend to achieve them and track progress throughout the year.

One of the most important parts of reviewing quality and setting quality priorities is to seek the views of our service users, staff and key stakeholders. This year we carried out a survey of all those involved with the Trust to discover what their concerns were. From this we drew up a long list of priorities which we put to a public vote. Our nine quality priorities for 2017-18 are the final result of this process.

The Quality Report also includes statements of assurance relating to the quality of services and describes how we review them, including information and data quality. It also includes a description of audits we have undertaken, our research work, how our staff contribute to quality and comments from our external stakeholders.

In addition to complying with the Quality Accounts Regulations, NHS Foundation Trusts are required to follow the guidance set out by NHS Improvement, which includes reporting on a number of national targets set each year by the Department of Health. Through this Quality Account, we aim to show how we have performed against these national targets. We also report on a number of locally set targets and describe how we intend to improve the quality and safety of our services.

If you or someone you know needs help understanding this report, or would like the information in another format, such as large print, easy read, audio or Braille, or in another language, please contact our Communications Department.

If you have any feedback or suggestions on how we might improve our Quality Report, please do let us know either by emailing Communications@candi.nhs.uk.

5.3 Language and terminology

It is very easy for people who work in the NHS to assume that everyone else understands the language that we use in the course of our day to day work. We use technical words to describe things and also use abbreviations, but we don't always consider that people who don't regularly use our services might need some help. In this section we have provided explanations for some of the common words or phrases we use in this report.

Benchmarking

Benchmarking is the process of comparing our processes and performance measures to the best performing hospitals, or best practices, from other hospitals. The things which are typically measured are quality, time and cost. In the process of best practice benchmarking, we identify the other Trusts both nationally and/ or locally and compare the results of those studied to our own results and processes. In this way, we learn how well we perform in comparison to other hospitals.

Care Quality Commission (CQC)

The CQC is the independent regulator of health, mental health and adult social care services across England. Its responsibilities include the registration, review and inspection of services and its primary aim is to ensure that quality and safety standards are met on behalf of patients.

Care Records Service (CRS)

The NHS has introduced the NHS Care Records Service (NHS CRS) throughout England and Wales. This is to improve the safety and quality of your care. The purpose of the NHS Care Record Service is to allow information about you to be safely and securely accessed more quickly. Gradually, this will phase out difficult to access paper and film records. There are two elements to your patient records:

- Summary Care Records (SCR) - held nationally
- Detailed Care Records (DCR) - held locally

CQUIN

A CQUIN (Commissioning for Quality and Innovation) is payment framework that enables commissioners to reward excellence, by linking a proportion of the hospital's income to the achievement of local quality improvement goals.

Datix

Datix is a patient safety body that produces web-based incident reporting and risk management software for healthcare and social care organisations.

CareNotes

CareNotes is an Electronic Patient Records system that is able to store more in-depth clinical information. All staff who are directly involved with a service user/patient's care will have some level of access to this system.

Foundation Trust

NHS Foundation Trusts in England have been created to devolve decision-making to local organisations and communities so that they are more responsive to the needs and wishes of local people.

Friends and Family Test

This is a survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.

Improved Access to Psychological Therapies (IAPT)

IAPT is a national programme aimed at increasing the availability of talking therapies, such as cognitive behavioural therapy, on the NHS. It is primarily for people with mild to moderate mental health difficulties such depression, anxiety, phobias and post traumatic stress disorder.

Information Governance (IG) Toolkit

The IG Toolkit is an online system which allows NHS organisations and partners to assess themselves against Department of Health Information Governance policies and standards. It also allows members of the public to view participating organisations' IG Toolkit assessments.

Mental Capacity Act

The Mental Capacity Act 2005 is designed to protect and empower individuals who lack the mental capacity to make their own decisions about their care and treatment. Examples of conditions that might affect someone's mental capacity are dementia, severe learning disability, brain injury or a severe mental health condition. The law applies to people in England and Wales aged 16 or over.

Mortality

Mortality rate is a measure of the number of deaths in a given population.

The National Institute for Health and Care Excellence (NICE)

NICE provides national guidance and advice to improve health and social care. NICE's role is to improve outcomes for people using the NHS and other public health and social care services. Its main activities are:

- Producing evidence based guidance and advice for health, public health and social care practitioners.
- Developing quality standards and performance metrics for those providing and commissioning health, public health and social care services.
- Providing a range of informational services for commissioners, practitioners and managers across the spectrum of health and social care.

Patient Safety Incident

A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.

Quality improvement (QI)

Quality improvement is a structured approach to improving performance by first analysing the current situation and then working in a systematic way to improve it. It is now an integral part of the quality agenda and aims to make health care safe, effective, patient-centred, timely, efficient and equitable.

Risk Adjusted Mortality Index

Hospital mortality rates refer to the percentage of patients who die while in the hospital. Mortality rates are calculated by dividing the number of deaths among hospital patients with a specific medical condition or procedure by the total number of patients admitted for that same medical condition or procedure. This risk adjustment method is used to account for the impact of individual risk factors such as age, severity of illness and other medical problems that can put some patients at greater risk of death than others. To calculate the risk-adjusted expected mortality rate (the mortality rate we would expect given the risk factors of the admitted patients), statisticians use data from a large pool of patients with similar diagnoses and risk factors to calculate what the expected mortality would be for that group of patients. These data are obtained from national patient records.

Risk management

Risk management involves the identification, assessment and prioritisation of risks that could affect or harm the organisation or staff and patients. The aim is to minimise the threat that such risks pose and to maximise potential benefits.

Serious incident investigation

Serious incidents in healthcare are adverse events where the consequences to patients, families, carers, staff or organisations are so significant that they require some form of investigation. These cases will be investigated thoroughly and lessons highlighted to ensure similar incidents do not happen again.

Sign up to Safety

Sign up to Safety is a national patient safety campaign that launched in June 2014 with the mission to strengthen patient safety in the NHS and make it the safest healthcare system in the world.

Serious mental illness (SMI)

An adult with a serious mental illness will have a diagnosable mental, behavioural or emotional disorder that lasts long enough to meet specific diagnostic criteria. SMI results in serious functional impairment which substantially interferes or limits one or more major life activities.

Helping servcie users with dementia adopt a Mediterranean-style diet

Part 2

5.4 Priorities for improvement in 2017-18

This part of the report describes the areas for improvement that the Trust has identified for the forthcoming year 2017-18. The quality priorities have been derived from a range of information sources, including wide-ranging consultations. We have also been guided by our performance in the previous year and the areas of performance that did not meet the quality standard to which we aspire. Finally, we have been mindful of quality priorities at national level, not least the increased focus on mortality review within mental health.

In order to make the final selection, the Trust carried out a survey to gather the views of patients, staff, volunteers, members, governors and other stakeholders on what they felt we needed to focus on to ensure ongoing improvements to the quality of care. From this we drew up a long list of potential quality priorities for 2017-18 based on local and national feedback and performance information.

This long list was then put to a public vote, open to everyone involved with the Trust, and as result the following priorities were selected:

Priorities for improvement in 2017-18

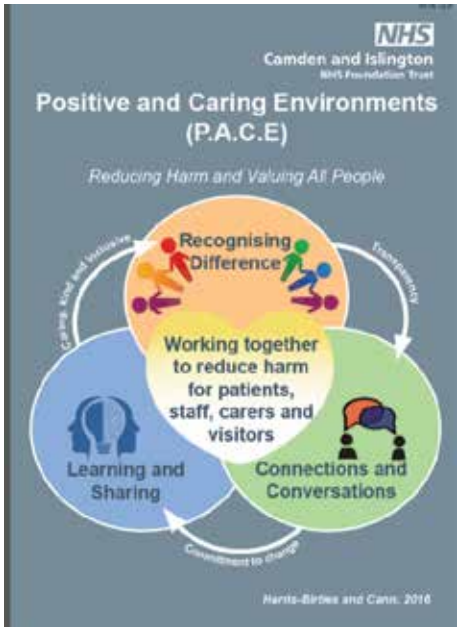
Patient Safety	
Priority 1	Promote safe and therapeutic ward environments by preventing violence
Priority 2	Provide comprehensive risk assessment
Priority 3	Reduce poor health outcomes for people with serious mental illness

Patient Experience	
Priority 4	Engage service users and staff in suicide prevention strategies
Priority 5	Better communication and involvement with families
Priority 6	Improve privacy and dignity for those with mental health needs who present to A&E

Clinical Effectiveness	
Priority 7	Ensure effective services by evaluating the outcomes from the Integrated Practice Unit for Psychosis
Priority 8	Better involvement of service users in developing and reviewing their care plans
Priority 9	Enable staff to protect service users through a good understanding of safeguarding and the Mental Capacity Act

How these priorities will be delivered

We are confident we can deliver these priorities, as there will be a project plan in place to support their achievement. Each of the quality priorities above will be monitored at the Local governance meetings and Quality Committee. Members of the Board will sponsor relevant priorities and implementation leads will be assigned for each quality priority. This will ensure accountability in terms of oversight for each priority throughout the year with a final update to the Board in Quarter four of 2017-18.



5.5 Patient safety

Priority 1:

Promote safe and therapeutic ward environments by preventing violence

Description of the quality issue and rationale for prioritising

All staff, service users and visitors are entitled to feel safe on the wards at the Trust. Violent incidents are potentially harmful and impact on staff and patient wellbeing. We want to promote safe and therapeutic ward environments by preventing violence, reducing restraints and supporting staff and patients following assault incidents. This work builds on last year's quality priority.

The reduction of patient on staff assaults will largely be achieved as a secondary gain of reducing restrictive practice. NHS Protect (2013)

Current picture

- Number of Prone restraints (excluding seclusion) Prone restraints account for 28% of all restraints. Planned prone restraints Currently 1.5% of all restraints
- Proportion of restraints being offered physical health checks following restraint 80%
- 81% of prone restraints involve the use of Intra Muscular (IM) medication
- Increase in violence and aggression incident reporting
- Positive and proactive training in place
- Introduction of Positive and Caring Environments Strategy (PACE)

Identified areas for improvements

- Reducing levels of violence in inpatient areas
- Reducing prone restraints
- Ensure physical observations are recorded when restraint has been used (After Action Review)
- Embedding PACE

How we will improve

- Continue to get more staff trained in IM injection alternative site training (the training has already been successful) This is a direct response to us identifying that nurses have predominantly only been trained to give IM injections in the Gluteal maximus. This necessitates the patient being prone in order to give IM medication.
- Roll out of positive and proactive care training to all members of the MDT including: rotations doctors, OT's, HCA's/Nurses and volunteers with the following topics covered:
  - Use of pharmaceutical care plans included in the Behavioural Support Plans
  - Use of debrief with staff and patients (using peer debriefs) in order to identify if there is anything that can be done differently

How we will measure success

- Prone restraints (excluding seclusion) to account for less than 16% of all restraints
- Number of planned prone restraints (as defined by C&I) to be less than 1% of all restraints
- Proportion of restraints being offered physical health checks following restraint above 90%
- 75% of patients that have been restrained had Behavioural Support Plans in place prior to incident, if a historical risk of violence had already been identified or after incident if no historical risk was identified
- Formally collecting feedback from staff and patients involved in violent incidents
- Numbers of violent incidents (a reduction)

Priority 2:
Provide comprehensive risk assessment

Description of the quality issue and rationale for prioritising

Learning from serious incidents has shown us that good clinical risk assessment is a key part of providing the best care to service users and preventing incidents of self-harm and harm to others. Risk assessments need to be comprehensive and include all relevant information. It is essential staff have the right skills and tools to carry out effective risk assessments.

Current picture

To improve the quality of risk assessments the Trust reviewed the risk assessment training. The updated training was implemented throughout 2016. The training is run on a monthly basis in partnership with Middlesex University. The Clinical Risk Assessment and Management Policy is currently under review and is expected to be finalised in July 2017. The policy will be re-launched to staff. A series of lessons learned workshops are being planned throughout 2017 to support the re-launch of the updated clinical risk assessment policy.

Identified areas for improvements

- Staff skills in risk assessment
- Risk assessment tools

How we will improve

- Risk Assessment and Crisis Planning will be audited in supervision with clinicians (for Service Users on Care Programme Approach(CPA).
- Undertake a quarterly randomised audit using the same supervision audit to assess impact on the quality of crisis planning and risk care plans.
- Evaluate training provided to staff on risk assessment
- Share lessons learned from serious incidents to staff regarding risk assessment
- Developing effective risk assessment tools (review and implementation of the Clinical Risk Policy

How we will measure success

- Carry out a baseline audit of risk assessments
- Re-audit after implementation of policy
- Formally collecting feedback from staff after risk training

Priority 3:
Reduce poor health outcomes for people with serious mental illness

Description of the quality issue and rationale for prioritising

Reducing premature mortality for people with serious mental illness is a national priority. The importance of monitoring and managing physical health care has featured in service user feedback, incidents and complaints.

Current picture

There are two current CQUINS relevant to this priority:

- Improving physical healthcare to reduce premature mortality in people with SMI: Cardio metabolic assessment and treatment for patients with psychosis. Demonstrated by a cardio metabolic assessment and treatment for patients with psychosis (in the following areas: inpatient wards, early intervention psychosis services, Community Mental Health Services patients on CPA
- Improving physical healthcare to reduce premature mortality in people with SMI: Communication with GPs. Demonstrated by an updated CPA care plan or a comprehensive discharge summary being shared with the GP

Identified areas for improvements

- How physical health is recorded and monitored to ensure consistency for service users with psychosis
- Communication with GPs

How we will improve

- Consistent recording of physical health status
- Regular review of physical health status
- GP name record in record
- Plan in place to support service users to register with a GP where necessary

How we will measure success

Measure the following:

- Completion of physical health records
- GP details recorded
- Discharge summaries and updated care plans
- Plan in place to address patients not registered with a GP

5.6 Patient experience

Priority 4:

Engage service users and staff in suicide prevention strategies

Description of the quality issue and rationale for prioritising

The government has made a public commitment to reducing self-harm and suicide and is asking all agencies to work together to reduce suicide.

Current picture

Suicide numbers have been steadily reducing as part of a national trend. There is a local suicide prevention strategy in place that was developed with partners. Learning from Serious incident investigations has identified areas for improvement in preventing suicides. The recommendations from the National Confidential Inquiry into suicides will inform this work.

Identified areas for improvements

- The Trust will focus on implementing the local suicide prevention strategy and making staff aware of the best approaches to detecting risk and targeting help and support to prevent suicide
- Involving service users, carers, and families in suicide prevention strategy

How we will improve

- Provide focussed staff training and guidance on asking questions suicidal thoughts
- Talking to service users and carers after serious self-harm incidents to learn from their experiences
- Providing support for people bereaved by suicide
- Sharing learning from investigations into suicides
- Better detection of high risk service user
- Targeting of suicide prevention and help to service users

How we will measure success

- Audit the recording of suicidal thoughts in the records
- Number of avoidable deaths due to suicide for service users
- Service user, carers and families feedback

Priority 5:
Better communication and involvement with families

Description of the quality issue and rationale for prioritising

The CQC Community Survey (2016) showed that we needed to improve communication and involvement with families. There is also a national drive to improve contact with service users, families and carers when there has been a serious incident.

Current picture

Serious incident and complaints feedback as well as service user surveys tells us that we need to be consistent in making contact with families and carers, and involving them. Another aspect of this is ensuring that carers and families have positive contacts with teams when in contact with the Trust. This is particularly important when there has been a serious incident.

How we will improve

- More consistent recording of information on next of kin and service user preferences for contact with families
- Update the serious incident policy to reflect the approach to communicating with service users, families and carers

How we will measure success

Measure the following:

- Recording next of kin
- Recording arrangements and preferences for involving carers and families
- Feedback from service users and carers on communication

Priority 6:
Improve privacy and dignity for those with mental health needs who present to A&E

Description of the quality issue and rationale for prioritising

Improving services for people with mental health needs who present to A&E is a national and local priority. The 2016 CQC inspection also identified this as a priority.

Current picture

In partnership with other Trusts there have been a number of improvements in Health Based Places of Safety to ensure patients are in a safe environment when they attend A&E, ligature points have been reduced. Our next step is to enhance the environment and make it comfortable for patients and carers.

Identified areas for improvements

- Privacy and dignity for service users using section 136 suites
- Keeping service users and their families comfortable and occupied during waits
- Keeping service users and their families informed about what will happen next

How we will improve

- Physical improvements to environment
- Regular reviews for patients in the suites
- Introduction of Self-Occupying packs

How we will measure success

- Regular audits (including patient experience feedback)
- Quarterly checklists that comply with the Healthy London Partnership Health Based Place of Safety standards

5.7 Clinical effectiveness

Priority 7:

Ensure effective services by evaluating the outcomes from the Integrated Practice Unit for Psychosis

Description of the quality issue and rationale for prioritising

Implementation of the IPU has been a significant step in transforming the way in which we deliver person-centred care and will result in better outcomes for our service users. The IPU will have a strong focus on prevention and self-management. Through the IPU we aim to reduce the death rate in the psychosis population and improve health and social care outcomes.

Current picture

We have just completed the first year of the five-year programme. More information on this is in part 2 of the report. As of 31 Dec 2016 data showed 90% for COPD care plan in place and 63% for diabetes care plan in place.

Identified areas for improvements

- Care plans in place for long term conditions
- Engagement with service users around self-management

How we will improve

Targeted improvement to complete care plans and interventions to engage service users in self managment.

What we will measure

- Outcomes audit of care plans in place
- Feedback from service users and key stakeholders on the IPU

Priority 8:

Better involvement of service users in developing and reviewing their care plans

Description of the quality issue and rationale for prioritising

Feedback from CQC visits and patient surveys tells us that we need to improve how we involve patients in developing and reviewing their care plans.

Current picture

There is a clear section on the care plan for the service user's signature. There are care plan templates in place to ensure consistency. However, care plans should be tailored to each individual. The practice development team has been supporting best practice-based approaches to care planning.

Identified areas for improvements

- Service user involvement in care plans
- Quality of Care plans
- Regular review of care plans

How we will improve

- Share best practice with staff and use review and audit to share learning on care plans

What we will measure

- Care plan audits looking at rate of patients signing and review dates
- Peer review care plan audits to look at the quality of the care plans

Priority 9:

Enable staff to protect service users through a good understanding of safeguarding and the Mental Capacity Act

Description of the quality issue and rationale for prioritising

The CQC inspection identified staff understanding of the Mental Capacity Act and safeguarding processes as an area for improvement. A number of improvements have already taken place to provide staff with training and ensure there is a clear process. This priority would focus on continuing these improvements by sustaining training rates for staff and auditing the process to measure improvement.

Current picture

The Trust has been delivering an action plan in response to the CQC's concerns. The plan includes further staff training and guidance, an updating of our safeguarding policy and a safeguarding 'dashboard' to provide improved oversight of referrals made by Trust staff.

Identified areas for improvements

- Training and guidance for staff

How we will improve

- Auditing the safeguarding and MCA processes
- Providing service based training

How we will measure success

- Audit results
- Training compliance at levels 1-2

Enjoying the artwork at the
Art of Caring exhibition at St Pancras

Part 3

5.8 What we have achieved in 2016-17

Progress against the quality priorities that we set for 2016/17

This section describes the Trust's progress against the quality priorities that we set for 2016/17. The Trust had 12 quality priorities for the year, reflecting both CQUIN targets and progress towards the CQC action plan.

Progress in 2017-18

Patient Safety		
Priority 1	We will establish a mortality and morbidity review process. **(Local priority – 'Stolen Years' Keogh recommendation)**	Partly achieved
Priority 2	We will ensure lessons are learnt from serious incidents. **(CQC Action Plan)**	Partly achieved
Priority 3	We will promote safe and therapeutic ward environments by preventing violence, reducing restraints and supporting staff and patients following assault incidents. **(Local priority – staff and patient wellbeing)**	Partly achieved
Priority 4	We will equip staff, through raising awareness and appropriate training to identify, prevent and reduce domestic violence and abuse. **(NICE Guidance and a local CQUIN)**	Achieved
Patient Experience		
Priority 5	We will involve service users and carers in the implementation of the clinical strategy. **(Local priority)**	Achieved
Priority 6	We will improve information given to service users about their medication. **(Local priority)**	Partly achieved
Priority 7	We will reduce non-clinical ward transfers. **(CQC Action Plan)**	Achieved
Clinical Effectiveness		
Priority 8	We will comply with the 18 weeks referral to treatment targets. **(National Guidance)**	Achieved
Priority 9	We will finalise and implement evidence based outcomes for the Integrated Practice Unit for Psychosis. **(Local priority)**	Achieved
Priority 10	We will increase the uptake of smoking cessation and promote a healthier lifestyle. **(CQUIN)**	Partly achieved
Priority 11	We will improve the understanding of outcomes of the specialist care pathway. **(Local priority)**	Partly achieved
Priority 12	We will increase staff knowledge and understanding of the Mental Capacity Act to enable practical application. **(CQC Action Plan)**	Achieved

Priority 1:
Establish a mortality and morbidity review

Partly Achieved

Why we adopted this as a priority

The Trust did not have a clear process for reviewing mortality as defined in the Keogh review on mortality. National reports from the CQC, National Quality Board and the Mazars report demand more open and transparent approaches to mortality investigation and reporting.

Identified areas for improvements

- We will nominate a Trust Lead for Mortality
- We will establish a Trust Mortality Review Group which will be a sub–committee to the Quality Committee
- Quarterly mortality report to Quality Committee and Board
- Benchmarking data against other Trusts
- Completion of thematic review of unexpected deaths
- Mortality data to be included on divisional dashboards (link to IPU outcome data on mortality)

What we have achieved

Over the last year we have:

- Appointed a Trust lead for mortality
- Established a Trust Mortality Review Group (MRG) which reports to the medical director. We also took account of the recommendations of the Care Quality Commission's report in December 2016, A Review of the way NHS trusts review and investigate the deaths in England.
- To take forward the learning from the Mazars report the Trust is holding weekly mortality review meetings to consider all patient deaths over the past week (Mazars categories are used). Preliminary reviews are also undertaken by the divisions to provide more information about care provided and any possible gaps that have been identified. In each case a decision is taken as to whether an investigation into the care and service provision is required and, if so, what level of investigation is appropriate.
- The MRG also receives weekly updates on the progress of all on-going investigations that have been reported on StEIS (the national database for reporting serious incidents)
- One of the MRG's functions is to provide regular reports on deaths within C&I. Since September 2016 patient demographics and categorisation of death have been recorded on a tracker system.
- Thematic reviews of unexpected deaths undertaken
- A mortality report sent to the Quality Committee including a plan for meeting the new national requirements on learning from death which will require quarterly reporting to the Board

Future challenges

We partly achieved this priority because we did not establish data reports in a way that allowed for accurate data reporting. In March 2017 Learning from unexpected deaths guidance was published. The Trust has an action plan in place to meet the new requirements. Mortality data is being reviewed in light of new national guidance and will be reported to services in a new format. As part of this process benchmarking can be undertaken.

A leadership project is currently reviewing the processes, data and reporting used by the MRG. As part of this process it visited North East London NHS Foundation Trust's governance team which was rated outstanding in its CQC inspection. Several key ideas that emerged from this visit will be incorporated into the project's recommendations for the MRG.

Priority 2:
Ensure lessons are learnt from serious incidents

Partly Achieved

Why we adopted this as a priority

Our aim is to establish methods of communicating lessons about serious incidents across the organisation and to demonstrate how lessons learned in one part of the service may have applicability to others. Above all, we recognise that following a serious incident (SI) Investigation it is vital to disseminate recommendations widely and then act on them.

Identified areas for improvements

- Systems and methods of communicating lessons across the organisation
- Bringing relevance and demonstrating applicability of lessons learned in other services when sharing changes in practice trust wide
- Standardise the delivery/agenda of the quality fora across the different divisions
- Establish reflective practice on all inpatient wards
- Establish quarterly learning exchange sessions, (quality half–day), where staff can share learning with other colleagues across the Trust
- Extend the remit of the serious incident review group to have greater focus on disseminating learning across the organisation
- Staff awareness of incidents occurring in their areas and Trust-wide
- Staff awareness of recommendations arising from serious incident investigations and relevant changes to practice
- The extent to which lessons learnt are embedding within services

What we have achieved

Currently each division within C&I holds a monthly quality improvement forum where serious incident report findings are shared. As a result specific goals are devised to be incorporated in people's daily work, discussed at team meetings and used in supervision.

The governance team has also produced a new quarterly learning bulletin which aims to share learning from recent incidents and complaints across the organisation. The first bulletin was sent to all staff in January 2017. The aim is to identify those areas where teams can implement changes that will really make a difference to service users and carers.

Learning Lessons Workshops introduced

The focus in these workshops is on building a non-threatening atmosphere of learning and highlighting when change has occurred. It is an inclusive workshop where anyone from the division is encouraged to attend. Guest speakers are invited, including Lead and Expert investigators or other staff that may provide specialist knowledge.

The learning bulletin which contains three incidents or complaints is reviewed. This provides the opportunity for thinking about the quality and rationale for reporting through different mediums as well as taking an analytical stance on what could be done differently. Sufficient time is allowed for each incident so that staff are able to consider thoughtfully and arrive at ideas for service implementation. These ideas are then drawn up on a flipchart to be used in the following month's bulletin.

Future challenges

This priority is partly achieved because there is still work to do to embed the work that has been done to share lessons learned in services. Therefore, a key focus over the next few months will be setting up feedback mechanisms within each division so that evidence of how and when recommendations are being implemented can be understood. Currently a leadership project is focusing on how all staff members can implement learning from SIs. One idea is to use vignettes to give context to an action point and to use the intranet, one-to-one supervision and team meetings to disseminate these.

The governance team is also working with families to produce a leaflet that describes how an SI investigation works. In addition we are looking into providing families with a family liaison worker.

We are currently undertaking a review of the serious incident process to ensure further improvements are made and learning is shared.

Priority 3:

Promoting safe and therapeutic ward environments; preventing violence and reducing restraints and supporting staff and service users following incidents of violence

Partly Achieved

Why we adopted this as a priority

Incidents of violence and aggression were the most reported type of event in the Trust last year. Moreover, when assaults against staff occurred, staff did not always feel confident to bring charges against the patient, further perpetuating the cycle of violence.

Identified areas for improvements

- Increase staff awareness of the value of pursuing a prosecution following assaults from patients, when deemed appropriate
- Ensuring that we have an adequately-skilled workforce to respond to the issue of violence
- Working in partnership with the police to pursue sanctions where appropriate and to support victims of violence
- Substantive appointment to Local Security Management Specialist post
- Number of violence incidents reported to see if improvements implemented result in a reduction of these incidents
- Benchmarking data against other Trusts. Through this we can liaise with better performing trusts to see what we can learn from them
- Staff feedback on experiences of violence and how incidents of violence are managed

What we have achieved

Over the past year we have appointed a Local Security Management Specialist (LSMS) and worked to increase staff awareness of the value of pursuing a prosecution following assaults from patients, when deemed appropriate.

In particular, we have:

- Developed a security management strategy aligned to NHS Protect's crime strategy
- Established effective relationships with local and regional anti-crime agencies to help protect staff
- Made security a key criterion in new build and refurbishment projects
- Implemented PACE
- An updated seclusion policy and all staff on PICU attending positive and proactive care training has led to significant decrease in seclusion use
- We have taken a number of actions to ensure staff are better supported

These include:

- All staff now know how to report a violent incident, theft, criminal damage or security breach
- All staff who have been victims of a violent incident have access to support services if required
- We use the Security Incident Reporting System (SIRS) to report details of all physical assaults on staff
- Induction leaflets explaining the need to report all incidents and contacts have been developed with Camden and Islington police stations
- Training available for staff in managing violence and aggression

Future challenges

The reason we have only partly achieved this outcome is despite efforts the number of violent incidents reported in the Trust in the last year rose from 291 to 362. An analysis of this increase shows that there is no specific factor underlying the increase. This is an area requiring more improvement and is being carried over into 2017/18 Quality Priorities. More work is planned to understand the increase.

A full scoping of currently technology to support searching has been completed and the trust has developed a business case to run a pilot project on four wards with the device (cellsense).

Six service user volunteers will be fully trained in breakaway and positive and proactive care. These volunteers can debrief for patients who have been restrained.

A further reduction reducing restrictive practice can lead to reduce in overall incidents of staff assault.

Priority 4:

Equipping staff, through raising awareness and relevant training, to identify, prevent and reduce domestic violence and abuse

Achieved

Why we adopted this as a priority

This priority reflected the national concern around domestic violence which resulted in a national CQUIN being put forward. We recognised the importance of timely detection of those vulnerable to domestic violence and taking action to mitigate tragic outcomes.

How we will improve

- Provide relevant training to frontline staff to support them in identifying and acting on domestic abuse
- Working with partner agencies to raise awareness of domestic abuse and the help and support available to victims
- Staff receiving training in safeguarding at level 1 and 2
- The extent to which our service complies with the NICE quality standard on domestic abuse
- Implementation of NICE guidance

What we have achieved

We have provided training to frontline staff to support them in identifying and acting on domestic abuse and worked with partner agencies to raise awareness of domestic abuse and the help and support available to victims.

Our Awareness and Response to Domestic and Sexual Abuse (AR-DSA) project, which ended in July 2016, was funded by the Department of Health and aimed to embed cultural change in the organisation. During the project's three-year life the Trust achieved all its objectives, including developing a domestic and sexual abuse policy, creating a staff training programme and producing a multi-agency risk assessment conference (MARAC) protocol for the Trust MARAC leads.

The Trust has now agreed to fund the Against Violence and Abuse (AVA) lead for a further 18 months. We have created an AR-DSA network which has representatives from a wide range of Trust services and links to service users on the Women's Strategy Group. We have also continued to run staff training courses and launched initiatives to engage with perpetrators of domestic and sexual abuse.

In addition:

- Evidence suggests that Trust staff are completing Datix when there is a disclosure which allows us to audit
- Trust intranet site has been refurbished so the safeguarding and domestic and sexual abuse resources are more easily available to staff
- Camden Safety Net will be piloting two domestic violence surgeries based at Greenland Road and Improving Access to Psychological Therapies (IAPT)

- MARAC leads will continue to lead on research and feedback as well as encouraging attendance. Although the MARAC referral rate for both boroughs is not high, the level of joint working between Trust staff and domestic violence agencies is very evident from the Datix reports, Carenotes and safeguarding meetings.

Training

Domestic violence and abuse form part of the safeguarding adult and safeguarding children Trust induction and core training. Levels 1 & 2 of the NICE guidance are incorporated into the delivery of Trust safeguarding training. The CQUIN target for Q4 target for training was achieved at 80.2% in terms of meeting of the NICE Level 1 & 2 domestic violence training within the Trust. Safeguarding is a priority for this year and there will be a focus on training.

Priority 5:

Involving service users and carers in the implementation of the clinical strategy

Achieved

Why we adopted this as a priority

The new clinical strategy was co-designed with service users and carers so we were keen to maintain their involvement and engagement throughout its implementation.

How we will improve

Identified areas for improvements:

- To maintain the engagement and involvement of service users and carers throughout the implementation phase of the Clinical Strategy

What we have achieved

The Trust held monthly 'evolution' meetings and workshops with service users and carers throughout 2016. These focused on the themes in the clinical strategy and looked at ways of improving service user engagement when delivering the strategy. This has already led to changes in the design of care plans to ensure greater service user involvement and an improved interface with primary care.

We have also developed a service user involvement strategy which aims to bring greater consistency to our approach, creating more opportunities for service users to get involved in all parts of the Trust and to co-produce service improvements and new service design. So, for example, service users are now represented on all job interview panels and are paid for any Trust work they undertake.

In addition we have restructured the Service User Alliance, which is where service user groups meet and share information. And we have now appointed a full-time Band 4 service user involvement facilitator.

Every division in the Trust now has service user representatives and as a result is adopting a more consistent approach to its service users. We have also started holding regular service user conferences. The first two were in December 2016 and April 2017.

Plans for engagement with carers are at a less advanced stage. We have co-designed a series of leaflets for carers on such topics as community services, acute day units and drug and alcohol services. We are also working on implementing the "triangle of care" which seeks to ensure a consistent approach to the needs of service users, professionals and carers.

Priority 6:
Medication management: Improving information given to service users

Partly Achieved

Why we adopted this as a priority

The Trust recognises the importance of ensuring that service users are given appropriate information about their medication, including side-effects and how best to manage them. The objective has been to ensure they receive this information in a format they are able to understand and at an appropriate time.

Identified areas for improvements

- Giving relevant information about prescribed medications, including dosages and side-effects
- Development and implementation of IPU
- Quarterly audit of records for evidence of information given in relation to prescribed medication
- Service user involvement in medication reviews

What we have achieved

Audits of patient records show that the information service users receive has improved (see Tables 1 and 2 below). However, were not able to meet the requirements around information on new prescriptions which are part of the national CQUIN.

Table 1. Percentage of patient records containing evidence that information has been provided to the patient about new medication prescribed.

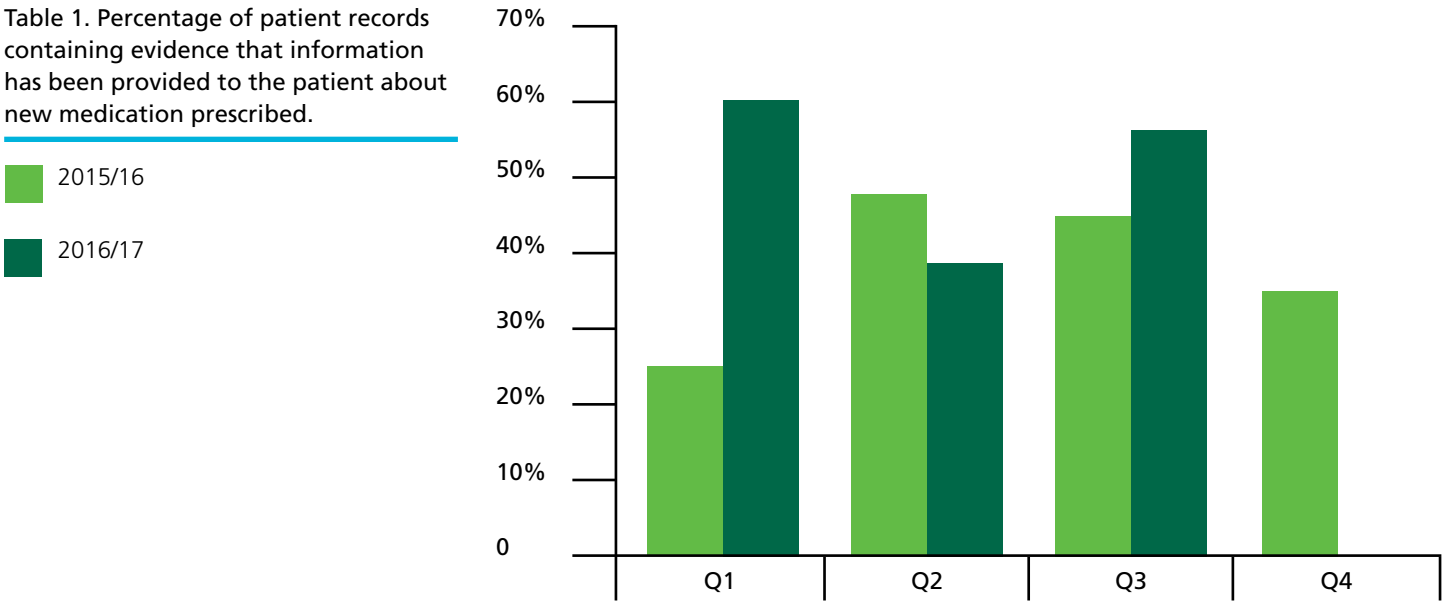
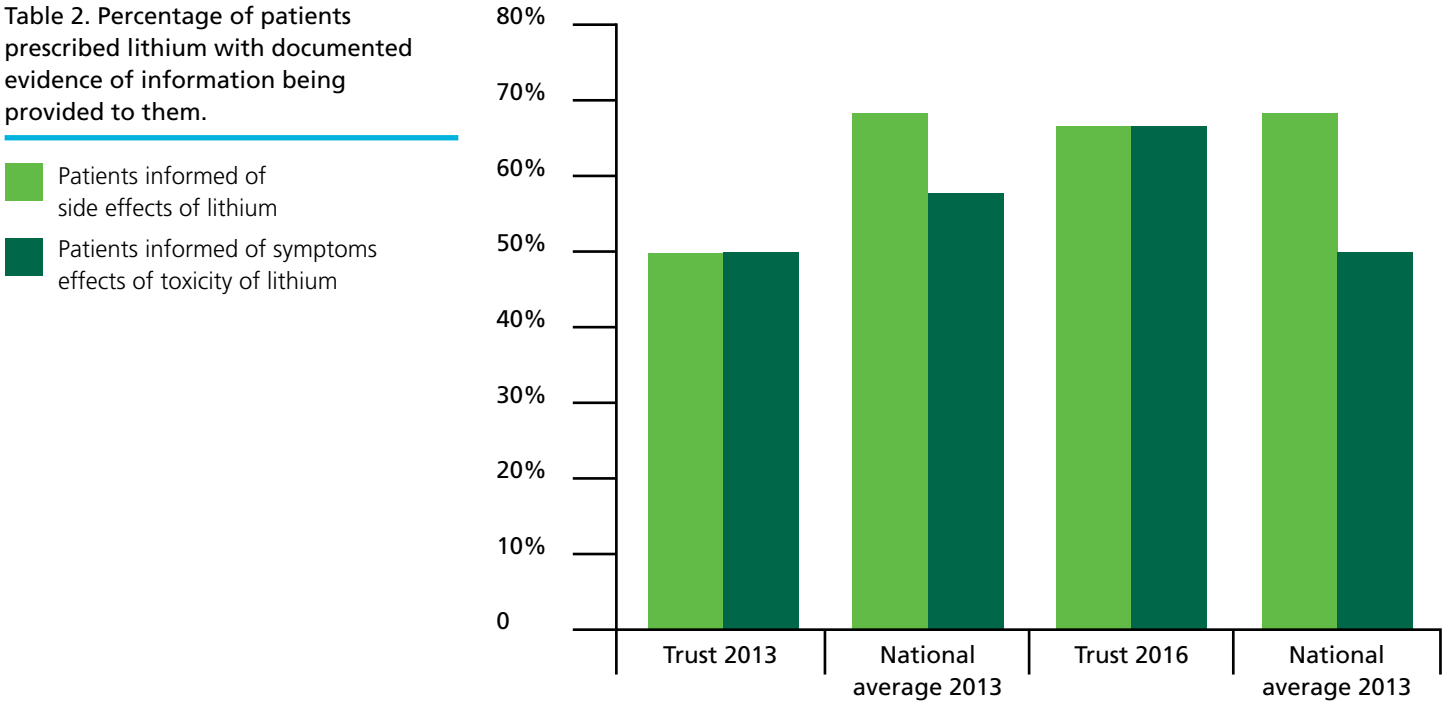


Table 2. Percentage of patients prescribed lithium with documented evidence of information being provided to them.



We recognise it is an ongoing task to ensure staff are trained and confident to provide information on medicines and document this in the patient records. A number of initiatives are under way to make sure we continue to improve and embed this in routine practice:

Staff training

We have developed a Medicines Management Train the Trainer course in house which is being implemented in 2016-17. The course includes modules on how to use the Choice & Medication (C&M) website effectively as well as counselling on medication, with specific reference to side-effects, follow-up monitoring and high risk medicines. Pharmacy staff are being trained to conduct individual medication reviews and counselling sessions as well as to facilitate group sessions for service users on medicine-related topics.

Information resources

The Trust currently subscribes to the C&M website which provides a comprehensive range of patient information leaflets on medication used in mental health. We have also subscribed to Medicines: A Patients Profile Summary (MaPPs) which produces an individualised summary of key information about a patient's medication (including physical health medicines).

Printed cards with details of the C&M website are supplied with all discharge medication.

An electronic version of the Glasgow Antipsychotic Side-effect Scale (GASS) has been developed in the electronic patient record (CareNotes). This informs service users of potential side-effects and enables a systematic review and assessment. The new physical health care assessment tool contains a link to the GASS tool. The clozapine-specific GASS tool has also been implemented in the clozapine clinics.

Provision of information

Service users should be provided with information on all new medicines prescribed. Hard copies of the most commonly used C&M information leaflets are now being pre-printed on the wards so that teams have ready access to them.

It is recognised that not all information can be provided or retained in a single discussion. For this reason we have been piloting different ways of providing information with a view to implementing across the Trust if successful. These include:

- Pharmacy and occupational therapy collaborative projects. Health and well-being sessions are delivered weekly to inpatients. Topics include weight and medication, insomnia, medicines and side-effects and smoking cessation. Pharmacy also delivers a session on medication and your lifestyle as part of the OT-run life skills programme.

- Pharmacy and service users are co-producing an 'Understanding your medication' course with St Pancras Hospital's Recovery College. The course aims to remove some of the barriers to understanding our relationship with medication and the professionals who recommend medication.
- Preparing for discharge. Prior to discharge pharmacy staff will counsel service users on their medicines as well as providing written information and reminder charts.

Future challenges

Improvements are still required to information on new prescriptions. Sustaining the improvements is also a challenge and the Trust will continue to monitor this area.

Priority 7:
Reducing non-clinical ward transfers

Achieved

Why we adopted this as a priority

The Trust's policy is absolutely clear that when somebody needs an inpatient admission, they will get one. At times when bed occupancy is high (>95%) this may mean some people are moved between beds for non-clinical reasons so that those in greatest need have the most appropriate bed. This priority was aimed at ensuring such moves were kept to the absolute minimum.

How we will improve

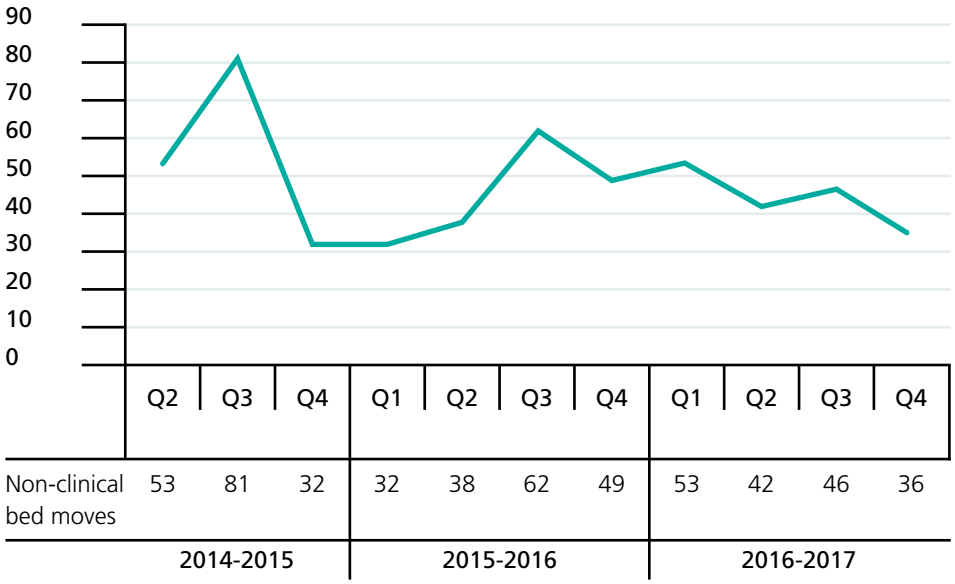
- Implement Review and systematic monitoring for each non–clinical ward move to better understand themes and reasons for these occurring
- Strengthen the process for moving patients between wards and having clearly set guidelines for managing this
- Number of ward moves each month and where they are occurring

What we have achieved

We are pleased to note that following an increase in our number of beds in April 2016 we managed to achieve several months of managing demand within our own bed base - despite the increased bed pressure. This means we have not had to transfer patients into hospital beds provided by other organisations.

We know there is a direct relationship between high levels of bed occupancy and non-clinical ward transfers. Excess demands for either male or female beds can also create a peak in non-clinical transfers. However, our data, presented below, shows that despite an occupancy rate of between 98-99% in 2016-17 the number of non-clinical transfers has not increased significantly compared with last year.

Non-clinical bed moves



We focused on ensuring that when these moves happened, they happened safely and effectively, with comprehensive handovers. We continue to work to ensure these do not happen during the evening or night-time, that patients are not moved more than twice and that moves for non-clinical reasons only occur when absolutely necessary. The inpatient management team applies strict rules for all non-clinical bed moves and manages these moves closely. This includes escalation processes and conference calls to ensure any such moves are planned appropriately.

We have also conducted a retrospective review of a sample of non-clinical moves to ensure the transfer protocol is being followed and to establish how the patterns of peaks and troughs relate to bed occupancy.

Priority 8:

Compliance with the 18 weeks referral to treatment targets for Improving Access to Psychological Therapies (IAPT) and Early Intervention Services (EIS)

Achieved

Why we adopted this as a priority

Meeting accessibility standards for IAPT and EIS services was made a national priority in 2015-16. The measures – which were also adopted as a priority by the Trust - are an indication of the quality of mental health care at service level, ensuring care is effective and safe. The aim is for 50% of people experiencing a first episode of psychosis to be treated with a NICE-approved care package and for 95% of people referred to IAPT to receive treatment within 18 weeks.

How we will improve

- People referred to IAPT receiving treatment within the specified 18 weeks standard
- Number of people receiving a NICE-approved care package

What we have achieved

We are on target to achieve the NHS Improvement targets during 2016-17. The data will need validating by the commissioning support unit to confirm the achievement.

NHS Improvements Targets 2016-17.

Service Performance Target – Improving Access to Psychological Therapies (IAPT)	Target	Q4 Performance
People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral:		
Camden	75%	82.4%
Islington		81.8%
Kingston		94.9%
People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral :		
Camden	95%	98.8%
Islington		99.1%
Kingston		99.0%

Early Intervention Services	Target	Q4 Performance
People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral	50%	87.5%

Priority 9:
Integrated Practice Unit (IPU)

Achieved

Why we adopted this as a priority

The Trust began developing the Integrated Practice Unit for psychosis – or integrated pathway – last year as a means of transforming the way we deliver person-centred care and improving outcomes for our service users.

Identified areas for improvements

- Management of physical healthcare for psychosis patients, particularly the management of diabetes and COPD
- Develop the IPU
- Develop the reporting framework for the agreed outcomes

What we have achieved

In the first year of the programme we have trained a large number of the Trust's nurses to assess and treat physical health conditions such as diabetes and lung disease. We have also successfully run a number of smoking cessation classes (see Priority 10 for figures on training and cessation). And between September and December 2016 we collected 500 patient-reported outcome measures.

The programme's outcome measures have now been finalised and signed off by all the partners. It is intended that the partners will include these as quality indicators in their contracts.

We recognise this is the beginning of a fundamental change in the way we provide services for people with psychosis. It is estimated that half of all those with psychosis are in contact with C&I at any given time with the other half receiving care through primary care. We will work more closely with health and social care colleagues outside the Trust to ensure these patients can be supported in a co-ordinated way with care packages built around individual needs. The next stage will be to agree an information sharing agreement with primary care and to conclude a formal contract between all the partner organisations.

Future challenges

We are currently monitoring clinical outcomes through our balanced scorecard while we wait for wider system reports from the Commissioning Support Unit. This priority will be carried over into 2017-18 Quality priorities, where improvements will continue to be monitored.

Priority 10:
Smoking cessation and substance misuse

Partly Achieved

Why we adopted this as a priority

Smoking cessation and access to substance misuse services were chosen as clinical priorities last year as part of the development of the IPU. It enabled us to continue the work that we were doing as part of a CQUIN to promote a smoke-free lifestyle, improve our service users' physical health and ensure they received an assessment in relation to substance misuse. The CQUIN focuses on training staff to enable them to undertake the assessment and provide appropriate support to service users.

How we will improve

- To increase the uptake of smoking cessation advice and promote a healthy lifestyle
- Continuing to offer nicotine replacement therapy to our service users
- Ensuring management plans are put in place to support service users with smoking cessation and substance misuse
- Offering brief advice to service users identified at risk of substance misuse

What we have achieved

Substance misuse

A CQUIN agreed in March 2016 set out targets to implement an agreed substance misuse screening tool to several frontline services via an online e-learning package. Our target was that 59% of agreed teams be trained by Q4 (Qtr 4 figures to be added).
A brief, accessible screening tools training package has been completed on the Trust "training tracker" platform. This package includes referrals advice and screening tools for opiate overdose and substitution therapy, alcohol withdrawal and B6 replacement.

All appropriate staff have also completed a larger, more comprehensive e-learning based training package. This package is designed to inform and support staff from different healthcare branches. It contains both commonly known Mental Health Act information as well as updates on substance misuse.

- Keep monthly dialogue with the main points of referral to SMS and MH teams
- Collect monthly usage data via EPR/care notes team
- Discuss issues with service managers and directors. A training plan has been agreed in the new policy
- Maintain ongoing dialogue with current service user (SU) groups. Links with Islington Borough User Group (IBUG) and Camden Borough User Group (CBUG) frontline are already in place.

Smoking cessation

Smoking prevalence remains fairly constant, in the range of 50-80%, among those experiencing mental health problems. In the general population it has fallen to an average of 20% in recent decades. Smoking increases the risk of some mental health problems, including anxiety and depression, and can make pre-existing conditions worse. Smoking tobacco (as opposed to using nicotine replacement therapy) also disrupts the action of most psychoactive medicines, with smokers typically requiring higher doses. We are therefore committed to enabling service users to quit in pursuit of improved physical health and sustained recovery.

The Trust is addressing smoking and tobacco dependence through:

- Training staff from all disciplines to a level appropriate to their role, from basic awareness of smoking related harms and remedies to delivering smoking cessation interventions
- Appointed a Trust lead for smoking cessation
- Recruitment of two specialist nurses to promote smoking cessation
- Increased availability of nicotine replacement therapy (NRT) in all forms

The total number of staff trained in smoking cessation since April 2015 is 193 (see below).

	Level 1	Level 2	Level 3	Total
No of staff trained in smoking cessation	151	34	8	**193**

In addition 208 service users (with severe mental illness were offered smoking cessation). Just under half (102) declined the offer, a significant number have reduced – or plan to reduce - their smoking and 27 have quit altogether.

We have identified a number of areas for further improvement and intend to:

- Train more staff to deliver smoking cessation interventions
- Ensure all newly referred service users are advised on where to access help to quit
- Make electronic cigarettes more available to service users
- Incorporate smoking cessation as a core component of all care plans, whether the therapeutic goal is to maintain current smoking status, reduce harm or to quit
- Engage service user groups in formulating revised smoking policies using a co-production approach.

Future challenges

Improvements are still required and the Trust is refreshing the strategy to ensure staff and service users are supported to quit smoking.

Priority 11:
Understanding the outcomes of the specialist care pathways

Partly Achieved

Why we adopted this as a priority

It is important that we understand and evaluate the outcomes of our specialist pathways so that they can be constantly improved. Pursuing this priority has also involved staff training on substance misuse assessment within mental health services.

How we will improve

Through defining and measuring outcomes and making improvements based on this.

What we have achieved

This was an ambitious priority but we have made great progress in defining and establishing outcomes which will enable us to make improvements based on evidence from service performance. There is still work to be done in some areas to define key outcomes which is why the priority was partly achieved.

Community mental health division (CMH)

a. Traumatic Stress Clinic

Outcome measures which are routinely used include PCL-5 (PTSD Checklist version 5) for post traumatic stress syndrome, PHQ-9 (Patient Health Questionnaire) and WSAS (Work and Social Adjustment Scale). These are administered at assessment, before the start of treatment and at the end of treatment as well as at various points during treatment to track progress. We also use a range of other outcome measures for our group interventions to track progress.

b. Complex Depression Anxiety and Trauma (CDAT) service

The individual psychological treatment measures used are BDI (Beck Depression Inventory), BAI (Beck Anxiety Inventory), and WSAS (Work and Social Adjustment Scale). In addition disorder specific measures are employed where appropriate. These are administered at assessment, before the start of treatment and at the end of treatment as well as at various points during treatment to track progress. Behavioural activation groups collect BDI, BAI and WSAS data. We also use a comprehensive range of pre- and post-intervention measures to assess the efficacy of transcranial magnetic stimulation. We also are about to introduce some individualised goal attainment scaling.

c. Psychotherapy service

The psychotherapy service uses a client self-report questionnaire designed to be administered before and after therapy for both individual and group treatment. The client is asked to respond to 34 questions about how they have been feeling over the last week, using a five-point scale ranging from 'not at all' to 'most or all of the time'. The 34 items of the measure cover four dimensions:

- Subjective wellbeing
- Problems/symptoms
- Life functioning
- Risk/harm

The questionnaire is repeated after the last session of treatment with the comparison of pre-and post-therapy scores offering a measure of 'outcome'.

Serious mental illness

We also have specific targets for smoking (reducing incidence from 44% to 40% over the next five years), COPD screening (to rise from 70% to 75%), flu vaccinations for people with SMI and COPD (50% to 58%) and the number of patients with blood pressure of 140/80 or below (69% to 74%). A new screening programme to identify those with diabetes (currently believed to be three times higher than in the general population) is expected to see an increase because of better screening techniques before a slight fall in the final year of the programme.

The pathways will be measured though a combination of patient-reported outcome measures and other clinical, public health and mortality data. The first three measures relate to overall mortality, premature mortality and suicides. New national guidance will support the monitoring of this. We are taking steps to introduce measurable improvements over the next five years in, among other things, patients' quality of life, symptomatic control, self-management, access to services, dignity, respect and absence of stigma, personalised care and side-effects from anti-psychotic medication.

Substance Misuse Service (SMS)

The pathways will be measured through NDTMS submitted data. The first measure is successful completions. Our target is for 8% opiate, 40% non-opiate, 40% alcohol and non-opiate and 45% alcohol-only service users as a proportion of the caseload to exit treatment drug free or as an occasional user. In Camden at the end of Q3 75% of the opiate target, 71% of the non-opiate and 60% of the alcohol and non-opiate targets were met. In Islington, 38% of the opiate target was met, non-opiates exceeded its target by 50%, alcohol and non-opiate and alcohol-only completions met 73% of their respective targets. Individuals achieving this outcome demonstrate a significant improvement in health and well-being in terms of increased longevity, reduced blood-borne virus transmission, improved parenting skills and improved physical and psychological health.

In addition, we have a 90% target for the completion of the Treatment Outcomes Profile (TOP) of which we are 100% compliant for starts, reviews and exits at Q3 (update). TOP measures the changes and progress in key areas of the lives of people being treated in drug and alcohol services and aids the achievement of key outcomes. There is a 96% target for effective engagement in treatment – that is, retaining service users in treatment for 12 weeks or discharging them successfully. By the end of Q3 86% of our users met this target.

Priority 12:

Increase staff knowledge and understanding of the Mental Capacity Act (MCA)

Achieved

Why we adopted this as a priority

Understanding of the Mental Capacity Act (MCA) was varied across the Trust and had been raised as a concern in the CQC inspection. We recognised we needed to do more by tracking our progress against this important priority throughout the year.

How we will improve

- Increase the availability of training on the Mental Capacity Act and applicability in clinical situations
- Working with teams to ensure understanding of responsibilities and the importance of documenting all MCA decisions
- Numbers of staff receiving Mental Capacity Act training
- Records audit to ensure that Mental Capacity Act decisions are appropriately documented

What we have achieved

MCA training is mandatory for all clinical staff in the Trust and covers not only legal requirements but also applying the MCA in clinical situations. All new clinical staff receive training in this area as part of the Trust induction programme. Existing staff are trained through an MCA workbook. Upon completion of the workbook the staff member takes a test to check understanding, which is then marked by the Mental Health Law Hub (MHLH). As a result of these initiatives, 83% of all the Trust's staff have now received training on the MCA.

- The MHLH has also developed MCA recording tools on the EPR system for all staff to use. Assessment forms to record capacity tests and best interests assessments are available on the EPR system. Other initiatives include:
- MCA and Deprivation of Liberty Safeguard (DoLS) flowcharts have been devised to help clinicians know when and how to apply the MCA and where to record tests for capacity and best interests.

- The MHLH has given presentations to all inpatient and community teams on how to record capacity and best interest assessments on the EPR system, stressing staff's responsibilities under the MCA and the importance of documenting all MCA decisions.
- The Trust organised an MHLH roadshow in November 2016 to increase staff knowledge and understanding of mental health law in general and mental capacity law in particular
- Earlier this year the MHLH launched a new initiative enabling a group of clinicians to become mental health law champions. They received specific training on the MCA and are now responsible not only for advising their teams/colleagues on MCA issues but also for monitoring compliance with the legislation. We now have a mental health law champion in the Acute, R&R and SAMH divisions as well as in the Recovery College.
- The MCA lead has now completed an audit on EPR to ensure that MCA decisions are appropriately documented.

Future challenges

We have met the initial challenges we set for MCA in 2016. However, we believe there are still further improvements to be made to improve staff understanding of this area. The Trust is carrying over this priority into 2017-18 in conjunction with safeguarding as it is an important area of quality for service users that we can further improve and sustain.

Mental health nurse, Charlotte Evans, has developed a unique exercise programme for service users

5.9 Statements of assurance from the Board

During 2016-17, Camden and Islington NHS Foundation Trust provided and/or sub-contracted the following four NHS services across approximately 40 sites in Camden, Islington, Westminster and Kingston:

- Adult Mental Health
- Services for Ageing and Mental Health
- Substance Misuse
- Learning Disability

Camden and Islington NHS Foundation Trust has reviewed all the data available to it on the quality of care in each of these NHS services.

The income generated by the NHS services reviewed in 2016-17 represents 100% of the total income generated from the provision of NHS services by Camden and Islington NHS Foundation Trust for 2016-17.

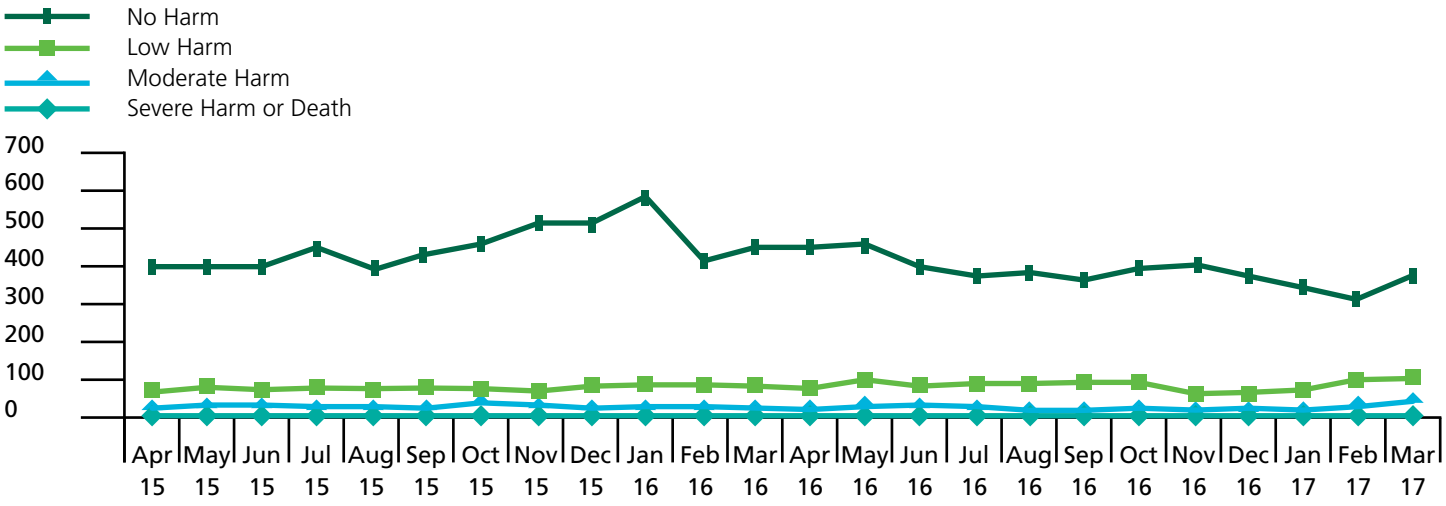
The Trust has been able to review data for each of these services in the areas of patient safety, patient experience and clinical effectiveness, and the Board has received regular comprehensive updates and reports on quality throughout the year.

An overview of the quality of care offered by the NHS foundation trust:

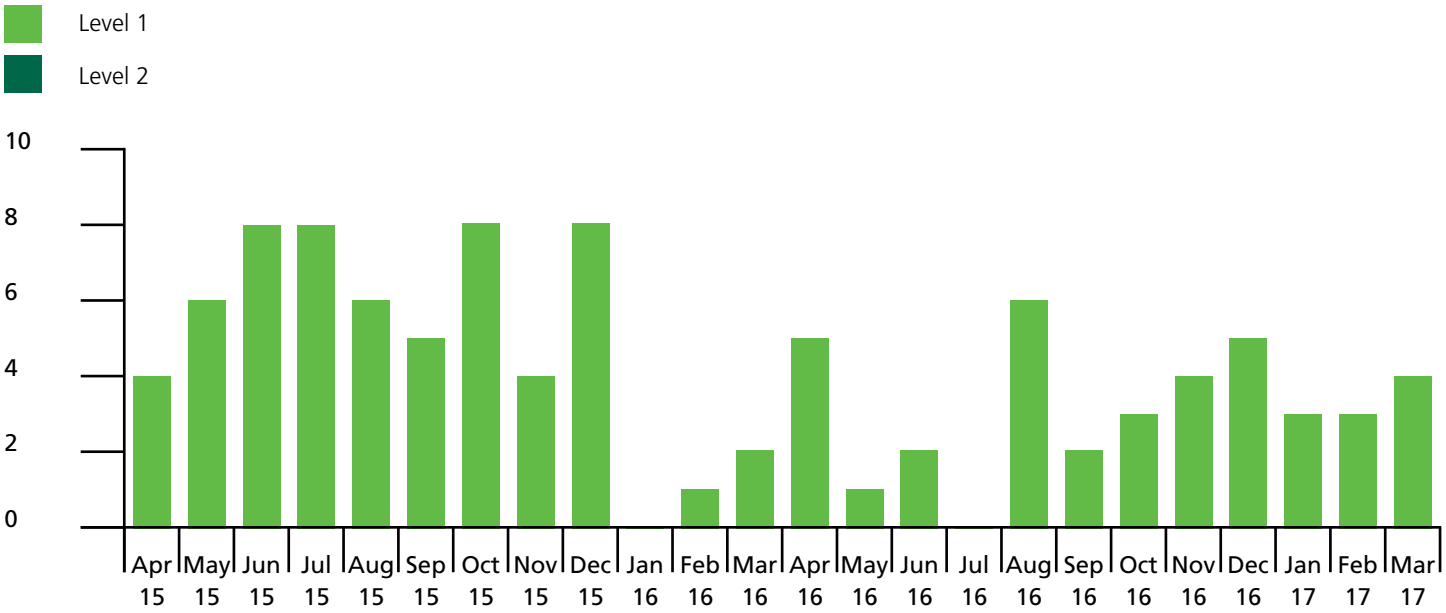
Key indicators of safety, effectiveness and patient experience

Patient safety

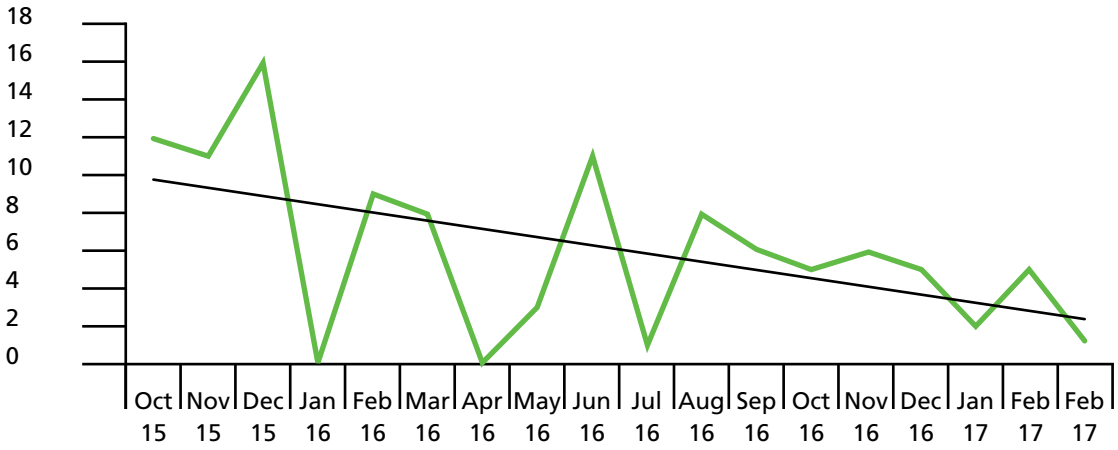
There was a decrease in incidents reported on the previous year. The Trust is further examining and will address if necessary as a good safety culture is indicated by a high reporting level.



Total Serious incidents



Seclusion: A sustained reduction in the use of seclusion has occurred due to interventions based on training and guidance.



Patient experience indicators

Friends and Family Tests responses have improved and complaints have fallen. The Trust plans to reinvigorate the patient experience strategy.

FFT 2015/16 - 2016/17

Financial Year	2015/16				2016/17			
Quarter	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
FFT Responses	141	354	377	474	516	470	697	789
% Recommend	82%	79%	86%	89%	88%	92%	89%	89%

FFT 2015/16 - 2016/17 / Complaints

Survey Year	2015/16	2016/17
Overall Experience Score	68%	69%

Survey Year	2015/16	2016/17
Number of complaints	190	170

Clinical effectiveness

The Trust is reviewing approaches to length of stay and avoiding emergency readmissions.

Average length of stay

	Target	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
Average length of stay Assessment Wards	<10 Days	13.4	11.3	11	12.1	13.6	14.5	12.59	10.8

Re-admissions

	Area	Target	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 15/16	Q2 16/17	Q3 16/17	Q4 16/17
Emergency Psychiatric Re-admission (28 days)	Camden	<6.2%	10.7%	7.7%	2.9%	4.2%	13.9%	9.2%	12.5%	10.5%
	Islington		8.5%	6.2%	9.8%	9.3%	10%	8.7%	9.6%	6.2%

	Area	Target	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
Emergency Psychiatric Re-admission (90 days)	Camden	<10%	17.6%	16%	12.9%	18.3%	24.7%	23.0%	23.8%	23.7%
	Islington		19.4%	16.8%	16.6%	19.2%	18.8%	19.1%	16.7%	12.3%

Participation in clinical audits

National audits

a) The Prescribing Observatory for Mental Health (POMH-UK) facilitates national audit-based quality improvement programmes open to all specialist mental health services in the UK. Results for different audits will be published intermittently throughout the year based on the POMH–UK schedule

b) Cardio metabolic assessment for people with schizophrenia (CQUIN)

c) The Early Intervention in Psychosis Audit (AEIP).

The Trust will continue to participate in the next round of POMH-UK audits in line with the schedule. Results of completed audits will be reviewed once published and improvements to prescribing practices implemented in line with recommendations. Audit results will also be disseminated locally to share learning.

In previous years, Camden and Islington has completed the Mental Health Indicator for Cardio Metabolic Assessment audit, as part of the Trust's CQUIN programme. In 2016-2017, both inpatients and community teams were included. The Trust is awaiting the publication of the final result which will be shared with participating teams across the Trust.

The table below summarises the national audits that the Trust participated in, the data collection periods and the number of cases submitted for each one:

Summary of National audits

Audit Title	Data Collection Period	Number of Cases Submitted	Actions
POMH 11c – Prescribing anti-psychotic medication for people with dementia	April 2016	121	Guidance and support are provided to ensure appropriate prescribing
POMH 7e – Monitoring of patients prescribed Lithium	June 2016	35	Guidance and support are provided to ensure appropriate prescribing
POMH 16a – Rapid Tranquilisation	September 2016	29	Guidance and support provided to ensure safe practice
POMH 1g and 3d - Prescribing high dose and combined anti-psychotics	February 2017	Currently completing data collection	The CQUIN work for cardio metabolic assessment for people with schizophrenia will be carried through for 2017/18 and the Trust will look to incorporate this with the improvement work linked to the IPU.
AEIP (Early Intervention in Psychosis) Audit	September 2016	104 (50 from Islington EIS and 54 from Camden)	IPU service in place to support psychosis care
Mental Health Indicator Cardio Metabolic Assessment	February 2017	150 – currently completing the data collection	

Participation in National Confidential Enquires

National Confidential Enquires

Audit Title	Data Collection Period	Survey requests
Homicide	16/17	4
Suicide	16/17	16

Findings from confidential enquiries inform the work on prevention of deaths.

Actions taken in response to national audits

Camden and Islington were scheduled to participate in four POMH audits in 2016- 2017 (Prescribing Observatory for Mental Health). These audits form part of the Trust's Pharmacy Audit Programme. The provider reports are shared with the Trust's Drug and Therapeutics Committee, Pharmacy colleagues and the relevant teams and services. Where necessary an action plans are created to improve results.

Local audits

During 2016/17 the Trust participated in a number of local audits both through the quarterly balanced scorecards and locally led divisional audits. Some local audits were linked to local quality improvement around the Mental Health Act and Mental Capacity Act, namely Section 132 and Section 17 Leave. Other audits were linked to the CQUINs around smoking care plans, the quality of crisis plans and patients who were offered the Malnutrition Universal Screening Tool (MUST) on admission.

The first clinical audit event of 2017 was held in January at Highgate Mental Health Centre. The entries this year were from across the Trust, incorporating a wide group of professions/specialties including nurses, pharmacists, psychologists and junior doctors. The topics covered included antimicrobial prescribing, emergency equipment, The Friends and Family Test and outcome monitoring within Camden and Islington Psychodynamic Psychotherapy Service.

Actions taken in response to local audits

Local audit results are shared by the audit participants within their local teams and relevant service areas. The learning from these audits are also presented at local clinical governance forums within each division and the Clinical audit event also presents an opportunity for audits to be shared more widely across the organisation. The learning and action plans from the quarterly balanced scorecard audits, are also shared both locally at team and service level and is reported at monthly divisional performance meetings. The Trust will run another audit event this year to facilitate the learning and sharing of clinical audit within the organisation.

The Trust's Mental Health Law team also has an annual audit programme. The learning outcomes gained from the Mental Health Law Audits a disseminated through the trust through the Mental Health Law Monitoring group where the results are scrutinised and discussed. The audits also feed into the MHL Training Group and the MHL Policy and Procedure groups to inform the training we are providing trust wide and to update policy and procedure within the Trust. Through membership of the Mental Health law committee and Monitoring group, Divisional Service Directors and Clinical Directors receive the outcomes of these audits. They are also reported in the Mental Health Law Champion Group so that they can be promoted in clinical settings.

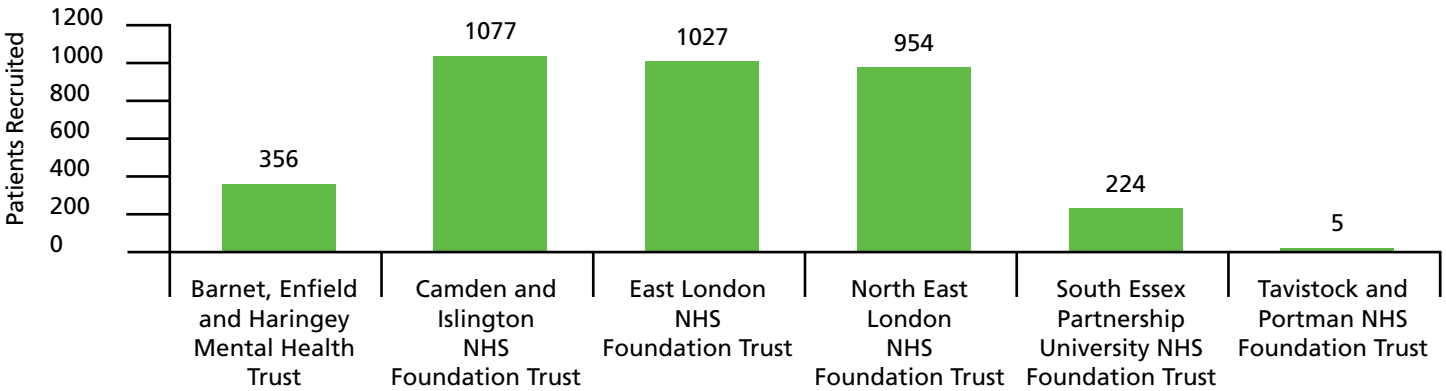
Participation in clinical research

The Trust has a strong track record of participating in clinical research and is rated second best in the country for research activity.

It has continued to build on an already strong relationship with University College London (UCL), its main academic partner. We also work closely with Division 4 of the Clinical Research Network (CRN) North Thames, which focuses on dementia, mental health and neurology, and seeks to increase opportunities for service users and the public to participate in, and benefit from, research.

The Trust is a partner organisation of CRN, which covers North Central London, East London, Essex and Herts, and is one of six mental health trusts in the network. In 2015-16 we were the leading trust for patient recruitment in mental health across North Thames (see graph below).

North Thames Mental Health Recruitment FY 2015/2016



Early indicators suggest we will remain the top recruiting mental health trust in 2016-17, with 89 studies currently active and 1,179 patients recruited to date, already an increase on last year's recruitment. Our academic partners have continued to attract a high level of grant funding to bring research into the Trust and we also host a growing team of researchers funded by the CRN.

Institute of Mental Health (IoMH)

The Trust continues to work with UCL to develop an IoMH presence and profile. The first academic symposium took place in September 2016, with more planned throughout 2017.

Biomedical Research Centre (BRC)

Mental health is now, for the first time, part of the remit of the Biomedical Research Centre (BRC), established between UCL and UCLH. Collaboration with the BRC will be central to delivering on research and innovation. It will help disseminate scientific findings in mental health and dementia and deliver improved treatments.

Quality and Innovation: the CQUIN framework

A proportion of Camden and Islington Foundation Trust's income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between the Trust and local Clinical Commissioning Groups (CCGs). The income from the CQUIN Scheme for Adults and Older Adults Mental Health Services amounts to £2.031 million total for income In 2016/17 conditional on achieving all quality improvement and innovation goals

The monetary total for the associated payment in 2015/16 was:

CQUIN total value - £1,974,972

CQUIN achievement - £1,260,374
(subject to confirmation by CCGs).

After negotiation with commissioners, C&I initiated a broad range of quality activities under the CQUIN scheme to improve the quality of care and the experience of both staff and service users. We implemented five national CQUIN schemes across the organisation and seven local schemes, based on local priorities.

The CQUINs agreed for 2016/17 between Camden & Islington Foundation Trust and our commissioners were in the following areas:

1 NHS staff health and well-being
2 Mental health
3 Substance misuse
4 Physical health
5 Prevention of domestic violence
6 Quality of crisis planning

The table over summarises how the Trust has fared in delivering its CQUIN targets:

Summary of National audits

Indicator	Q1	Q2	Q3	Q4*
1. NHS staff health and well-being				
1.1b Introduction of staff health and well-being initiatives Introducing health and well-being initiatives covering physical activity, mental health and improving access to physiotherapy for people with musculoskeletal issues.	Met	N/A	N/A	Met
1.2 Development of an implementation plan and implementation of a healthy food and drink offer Submitting data on the food suppliers operating on NHS premises and taking action in four areas including: banning price promotions, advertisements and sale at checkouts of food and drink high in fat, salt, sugar and saturates as well as ensuring healthy options are available for staff at night.	Met	N/A	N/A	Met
1.3 Improving the uptake of flu vaccinations for frontline clinical staff Achieving an uptake of flu vaccinations by frontline healthcare workers.	Met	N/A	N/A	Partially Met
2. Mental health				
2.1 Improving physical healthcare to reduce premature mortality in people with SMI: Cardio metabolic assessment and treatment for patients with psychosis Demonstrating cardio metabolic assessment and treatment for patients with psychosis in the following areas: inpatient wards, early intervention psychosis services, Community Mental Health Services patients on care plan approach (CPA).	N/A	N/A	N/A	Results will be available in June 17
2.2 Improving physical healthcare to reduce premature mortality in people with SMI: Communication with GPs An updated CPA care plan or a comprehensive discharge summary to be shared with the GP.	N/A	N/A	Met	N/A
3. Substance misuse				
Effective identification and management of substance use/misuse (year one of two-year substance use focused CQUIN) Evidence to be provided on the delivery and effectiveness of mental health staff training on identifying and managing substance use/misuse in individuals referred for mental health assessment and/or treatment.	Met	Met	Met	Met
4. Physical health				
4.1 Medicines New prescriptions should contain information about: reason for prescribing, dose/duration, method of delivery, side-effects, monitoring/review arrangements and self-management.	Not Met	Not Met	Not Met	Not Met
4.2 Obesity prevention and management in hospital settings This focuses on identification of obesity, assessment and management of overweight and obese children, young people and adults in hospital and the plan of care after discharge.	N/A	Met	Not Met	Not Met

Summary of National audits (Cont.)

Indicator	Q1	Q2	Q3	Q4*
4. Physical health				
4.3 Smoking cessation care plans The incentive seeks to improve the recording of smoking status in community and secondary care, increase access to effective support and offer treatment to stop smoking.	N/A	Met	N/A	Met
5. Prevention of domestic violence				
5.1 Staff training Number of eligible staff that have accessed level 1 and level 2 training.	Met	Met	Met	Met
5.2 Patients Number of people disclosing/experiencing domestic violence that are referred to a specialist service.	N/A	Met	N/A	Met
6. Quality of crisis planning				
Audits into the quality of crisis plans to ensure they are robust, personalised and timely.	Met	Met	Met	Not Met

* Q4 results are provisional pending confirmation from CCGs

**N/A means that there was no specify measure to meet in that period

5.10 Care Quality Commission (CQC)

Registration:

CQC register Camden and Islington NHS Foundation Trust services to carry out the following legally regulated activities.

Accommodation for persons who require nursing or personal care

Stacey Street Nursing Home

Treatment of disease, disorder or injury

St Pancras Hospital

Stacey Street Nursing Home

Highgate Mental Health Centre

Assessment or medical treatment for persons detained under the 1983 Act Registered services

St Pancras Hospital

Highgate Mental Health Centre

Diagnostic and screening procedures

Stacey Street Nursing Home

Highgate Mental Health Centre

Participation in reviews and investigations

CQC inspections

The Trust has participated in a full inspection by Care Quality Commission relating in February 2016 and produced its report and ratings in June 2016. Overall it rated the Trust as requiring improvement.

CQC Inspection Results

Overall rating for services at this Provider	Requires improvement
Are Mental Health Services safe?	Requires improvement
Are Mental Health Services effective?	Requires improvement
Are Mental Health Services caring?	Good
Are Mental Health Services responsive?	Requires improvement
Are Mental Health Services well-led?	Requires improvement

	Safe	Effective	Caring	Responsive	Well led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Community mental health services for people with learning disabilities or autism	Good	Good	Good	Good	Good	Good
Community-based mental health services for adults of working age	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Community-based mental health services for older people	Good	Good	Outstanding ☆	Good	Good	Good
Long stay/rehabilitation mental health wards for working age adults	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Mental health crisis services and health-based places of safety	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate
Substance misuse services	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Wards for older people with mental health problems	Good	Good	Good	Good	Good	Good

Mental health crisis services and health-based places of safety were rate as Inadequate. Wards for older people with mental health problems, community-based mental health services for older people, and community mental health services for people with a learning disability or autism were rated as Good overall

The inspection highlighted a number of areas of good practice, with a rating of 'good' across the board for older people's community services and inpatient wards and an 'outstanding' for caring. It also rated our staff, trust-wide, 'good' for caring, with the inspectors describing them as "responsive and respectful" and willing to go "the extra mile". However, the inspectors also concluded that a number of areas required improvement. To address the requirements we have a full priority action plan in place. We have made progress in a number of areas. The summary below shows the Must do areas we are required to improve by CQC and the key actions we have taken.

The CQC required action be taken in the following areas:

Must do Action required	Summary of key actions we are taking
Ensure the environment is safe, remove identified ligature risks, ligature risk assessments contain plans for staff to manage risks, including mitigation for obstructed lines of sight. Address safety concerns in the health-based places of safety.	The safer environment group has developed and introduced a clear system for assessing and managing ligature risks, with support and guidance for staff in place. There have been extensive works to reduce potential ligature points and provide clear lines of sight . A Section 136 working group has reviewed the current provision and governance arrangements against the draft London standards. Improvement works have been completed at two hospitals and the work at the third hospital awaits sign off.
Ensure repairs to the patient care areas are completed in a timely manner.	There is now protocol in place for registering, tracking and signing off (by team managers) of repairs. Regular monitoring of performance in place. A Reference Guide and Checklist for managing environments is completed.
Ensure robust and effective governance systems to monitor the quality, performance and risk management of services. Completion of: • Clinical records • Risk assessment • Care plans • Medication reviews • Clinic and medication storage fridge temperatures • Individual practitioner caseloads records	CareNotes will be improved to ensure that information recorded will be more streamlined, intuitive, and user-friendly. Records completion is assessed and report on the local service performance report. The Clinical Risk Policy is being updated to reflect best practice and guidance on completion. The Trust will develop standard operational guidance and checklists on how key records are to be maintained around care planning. Audits of patient involvement will be undertaken. The Trust has protocols in place for the physical health monitoring for patients on lithium, clozapine, and antipsychotics (including high dose antipsychotics). These are monitored through audit (including POMH). The numbers of Medication reviews completed are monitored and reported to services. The physical health-screening tool is now live on Carenotes. Temperature monitoring compliance is now included in the infection control environmental audit. Training is available for staff to share best practice. Individual practitioner caseloads is audited through the Monthly Managers Performance meeting.
Equipment on site for staff use in emergencies. Equipment is serviced regularly and decommissioned when no longer fit for purpose.	There is guidance for staff in place and emergency equipment available to teams. This is being audited to ensure compliance. A new contractor has now taken over the servicing and removal of all equipment.
Ensure all staff are meeting the requirements of the Mental Health Act and Mental Capacity Act.	The Trust has developed a flow chart to support staff with decision making and a SOP for Section 132 rights. Assessment forms have been added to Carenotes and a signposting message has been added to the login page regarding rights and capacity. The seclusion policy was reviewed. Over 80% of staff have completed the training. We plan more work around leave and after care.
Safeguarding information is recorded appropriately and staff understand the process.	Screensavers were used to raise awareness of safeguarding processes with staff. Online training is now on the training tracker. All teams display the safeguarding flowchart. The guidance has been updated and will be ratified in June 2017.
Staff receive an annual appraisal and staff training records includes specialised training.	Developing our People and Appraisal Processes and Policies has been launched as has a new recording system. An audit of supervision records will be carried out. We have simplified the training matrix for staff and added more e training modules to make it easier for staff to take part in training. A training tracker has been introduced for Core Skills Training for specific levels across teams.
The Trust must ensure there are sufficient experienced staff on duty at all times to provide care to meet patients' needs.	As safer staffing process is in place and the establishment has been increased in the acute areas.
The Trust must monitor people on the waiting list and identify any patients with increased risk to take appropriate action.	The Trust will undertake a review of how teams monitor those on waiting lists for increased risk and will implement an enhanced approach.
Mixed sex breach/beds/leave.	Female only bed areas in 154 Camden Road and Highview will be opened up.

The Trust will continue to working closely with commissioners and the CQC to further progress our improvements in the next 6 months.

Mental Health Act monitoring visits

As a Mental Health Trust the CQC carries out a regular cycle of MHA monitoring visits and we participated in nine MHA monitoring visits in 2016-17 to our wards. When recommendations are made the service completes an action plan that is monitored by the Trust mental health law committee.

5.11 Data quality

Information Management in the NHS is increasingly under scrutiny and the ability of care providers to produce accurate and reliable information is often used as a measure of governance, accountability and efficiency of modern NHS services. A high level of data quality is an essential facet of any NHS provider's ability to maintain service user safety. To that end, the Trust Data Quality Policy outlines the expectations for staff on how high data quality can be promoted and maintained within the Trust.

Camden and Islington Foundation Trust will be taking the following actions to improve data quality:

- Ensure all our staff are trained to record effectively on CareNotes (our electronic patient record system)
- Further enhancement of our Clinical Dashboard to check completeness of recording information on CareNotes
- Quality assurance process of the Mental Health Services Data Set and other external submissions
- Explore business intelligence options that can support an array of solutions and systems to support clinicians with data quality improvements

As a Mental Health provider we do not submit records to the Secondary Uses Service. We are required to submit data to NHS Digital.

- The most recent information from NHS Digital on Data Quality Maturity Index (DQMI) on percentage of patient records with NHS Number and General Medical Practice code is shown below,
- NHS number - 99%
- General Medical Practice code - 100%

5.12 Clinical coding

Camden and Islington Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

Information Governance Toolkit

Information Governance (IG) is about how NHS and social care organisations and individuals handle information.

The Information Governance Toolkit is a performance tool produced by NHS Digital. It draws together the regulations and central guidance related to information governance and presents them as one set of information governance requirements. For the 2016/17 submission, C&I's overall score was 96%, rated as a pass (green).

The Trust continually reviews its information governance framework to ensure all personal and medical information is managed, handled and disclosed in accordance with the law and best practice. In addition we attach great importance to training, data quality and clinical records management. As a result, we have seen improvements across the Trust.

5.13 Reporting against core indicators

The Trust is required to report our performance against a core set of indicators, which is published by NHS Digital. There are five indicators, which are relevant to the services we provide and below is our performance against this set of measures.

Core Indicator 1

Indicator	2016/17	National Target	Top Performer	Worst Performer	2015/16	2014/15
Patients on Care Programme Approach (CPA) followed up within 7 days of discharge from psychiatric inpatient stay	96.3% (Q4)	95%	100% (Q3)	73.3% (Q3)	95.2% (Q4)	98% (Q4)

Camden and Islington NHS Foundation Trust considers this data is as described for the following reasons - performance is monitored locally via the Trust's Business Intelligence systems which reports all discharges so that local performance teams can track patients who have or have not been followed up. Clinicians are alerted to those patients requiring follow up, ensuring focused and informed actions are taken.

Camden and Islington intends to improve this indicator, and so the quality of its services by upholding the CPA policy operational delivery of follow up contacts, publishing and sharing this information each month at Divisional Performance meetings and discussing this indicator at local management and team meetings.

Core Indicator 2

Indicator	2016/17	National Target	Top Performer	Worst Performer	2015/16	2014/15
Admissions to Acute wards where the crisis resolution home treatment team were gate keepers	100% (Q4)	95%	100% (Q3)	88.3% (Q3)	99% (Q4)	100% (Q4)

Camden and Islington NHS Foundation Trust considers this data to be as described for the following reasons - performance is monitored locally via the Trust's Business Intelligence systems which identifies all patients who were readmitted. The Trust supports staff with ongoing information on business rules ensuring activity is recorded and captured accurately.

Camden and Islington intends to take the following actions to improve the percentage score, and so the quality of its services, by developing robust systems to closely monitor this activity and alerts teams to any deterioration in performance.

Core Indicator 3

Indicator	2016/17	Local Target	Top Performer	Worst Performer	2015/16	2014/15
Patient readmitted to a hospital within 28 days of being discharged	10.5% (Camden) 6.2% (Islington)	6.2%	N/A	N/A	4.2% (Camden) 9.3% (Islington)	8.2% (Q4)

Camden and Islington considers the data to be as described due to the following reasons - we have developed our electronic patient record to ensure robust reporting systems are in place and have validation processes that assures data quality improvements. No comparable national benchmarking data has been available.

Camden and Islington Trust has not always achieved this target and intends to take the following action to improve this indicator, and so improve the quality of its services by enhancing the quality of discharge planning documentation, identify causes for readmission and share the lessons learned at operational management meetings. We aim to continue to monitor and report on this indicator routinely to all relevant areas across the Trust.

Core Indicator 4

Indicator	2016/17	Top Performer	Worst Performer	2015/16	2014/15
The Trust's "Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period	7.3	8.1	6.9	7.5	8.2

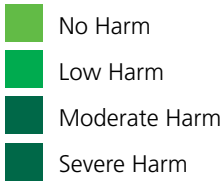
Camden and Islington considers the data to be as described due to the following reasons - the national Community Mental Health survey is compulsory for all Trusts. The data for this indicator is provided by the CQC and Department of Health.

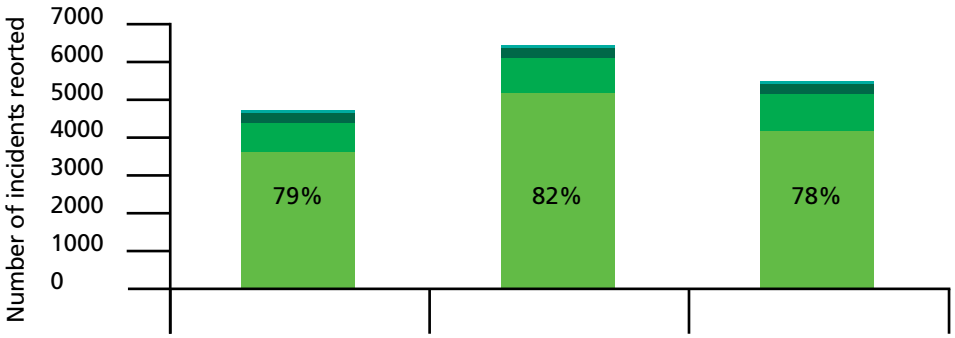
Camden and Islington intends to take the following actions to improve the percentage score, and so the quality of its services, by developing robust systems to closely monitor this activity and alerts teams to any deterioration in performance.

Patient safety incidents and the percentage that resulted in severe harm or death

Camden and Islington considers the data to be as described due to the following reasons - the data for this indicator is derived from Datix our internal patient safety software. Only a small fraction of our incidents results in sever harm. The Trust is committed to implementing a process to learn from serious incidents.

Severity of Incidents Occurring





5.14 Our achievements in quality improvement

We are in the process of introducing a five-year quality improvement programme in the trust with the aim of creating a culture of continuous improvement.

QI is an established method for testing and implementing changes. It gives staff the authority, responsibility and tools to make changes in how services are delivered with the aim of improving quality.

The impact of the programme will be measured in three ways:

- Reducing levels of avoidable harm
- Improving staff morale, demonstrated by C&I being in the top 20% of providers, according to the national staff survey
- Improving the patient experience, demonstrated by C&I being in the top 20% mental health providers, as measured by the Friends and Family Test.

A central QI hub is being created which will be responsible for engaging with staff and users to ensure everyone knows about QI and feels empowered to get involved in improving care. The hub will also build capacity and capability through education and training and support teams to deliver QI projects. There are also plans to develop a cohort of QI champions across the organisation.

The board will receive six-monthly progress reports on the programme. Implementation leads will also be assigned to each Trust-level quality priority.

Risk management

The Trust has an established process for managing risk and detecting and responding to quality concerns. Each division has a risk register that is monitored regularly to ensure any risks that cannot be managed within the division are escalated to the corporate risk register. The risk management strategy is reviewed annually, with the Audit and Risk Committee having oversight of this process.

A recent internal audit concluded that the Trust has a well-designed process for identifying strategic risk and escalating concerns for review. It also highlighted opportunities to consolidate the level of risk reporting to the Audit and Risk Committee to help it identify significant risks and take appropriate action. In line with the recommendations from this audit a new format for reporting to the committee is under consideration. This will be further developed in 2017-18.

Sign up to Safety

Sign up to Safety is a national patient safety campaign that was launched in June 2014 with the mission to strengthen patient safety in the NHS and make it the safest healthcare system in the world. This campaign wants to establish and deliver a single vision for the whole NHS to become the safest healthcare system in the world. The campaign aims to take all the activities and programmes that each of the NHS organisations currently own and align them with this single common purpose.

C&I signed up to this campaign in 2015 and has published its 'Safety Improvement Plan' on the Trust website and can be viewed here. By signing up, we have made five commitments, which are:

- **Put safety first:** Commit to reducing avoidable harm in the NHS by half and make public the goals and plans developed locally.
- **Continually learn:** Be more resilient to risks as an organisation, by acting on the feedback from patients and by constantly measuring and monitoring how safe services are.
- **Be Honest:** Be transparent with people about progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.
- **Collaborate:** Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.
- **Be Supportive:** Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate progress.

We have action plans to address the following areas:

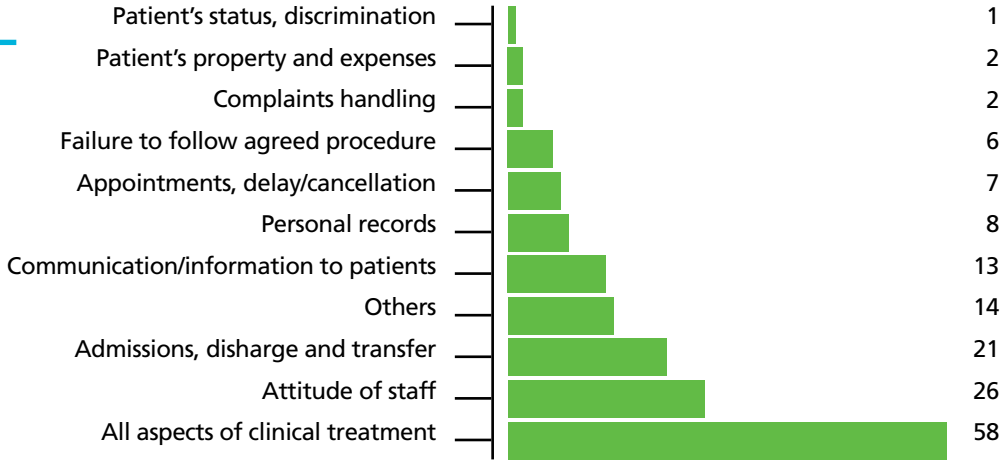
- Learning lessons from serious incidents
- Reducing falls
- Reducing non-clinical bed moves.

Complaints

The Trust received slightly fewer formal complaints this year than last year: There were 171 complaints compared to 190 in 2015/16. In addition, 210 concerns received via the Advice and Complaints Service were resolved informally. Of course, this only represents a proportion of the issues that staff resolve directly with service users on a daily basis (figures correct as at 20/02/17, will need to be amended at year end).

The chart below shows the different categories of complaint (to be updated at year end). Complaints about clinical treatment were by some way the largest category, followed by staff attitudes and admissions, discharge and transfer issues (which generally relate to access to service).

The different categories of complaint



The Trust is committed to using the feedback we receive through complaints to improve our services. All staff have a regular slot at their team meetings where any complaints can be discussed. Complaints which are either partially or fully upheld will have an action plan to ensure that recommendations are implemented. Action plans are discussed and reviewed at divisional quality forums.

The Advice and Complaints Service produces a newsletter which includes changes made in response to complaints, ensuring this information is shared across the organisation. These newsletters are now produced jointly with the Serious Incident team so that learning from both processes can be co-ordinated. This reflects the new-style Aggregated Complaints and Incidents report which is now being produced bi-monthly with an emphasis on identifying common themes in investigations. The Trust website also identifies lessons learned from complaints with examples of actions taken, so service users and carers can be assured their feedback really does make a difference.

The Trust continues to review and upgrade its complaints reporting systems to ensure we meet national reporting requirements. This also provides us with better quality information to help us respond in a timely manner to any themes or trends arising from complaints.

Below are some examples of improvements made in the last year as the result of feedback from complaints:

- We know that demand for some services outstrips currently available resources, leading to delays in service users being seen. We are working with our commissioners to try to address this. But in the meantime some of the affected teams have reviewed their referral pathways to ensure they are clear to both GPs and service users, so people know what they can expect from our services. Standard letters and leaflets have been updated to support this.

- The medicines management policy has been reviewed and amended to cover the situation where a person requiring admission to inpatient or crisis services is taking an unlicensed medication, or taking it for an unlicensed purpose.
- The home treatment teams have piloted a named worker scheme which they hope to roll out permanently over the coming months. This change aims to provide a more personalised service and offer a contact for service users.
- Communication issues are often part of the complaints that people raise with us. Sometimes this is about how we communicate with them directly - for example, telephones not being answered or delays in responding to messages. It can also be about communication between staff - for example, quality of handovers. All teams have been asked to consider these issues and to review how they can improve the quality of service we provide.
- A new trolley service run by our volunteer team for the inpatient wards on the St Pancras site will begin in the near future. It will offer a wider range of items for service users, particularly those who cannot leave the ward.

Depending on the complexity of the complaint, our internal Trust targets for responding to formal complaints are either 10, 25 or 45 days. We aim to respond to at least 80% of complaints within these timescales. However, despite this being a key focus for both the Advice and Complaints Service and the divisions, we have struggled to meet these targets.

From Quarter 3 we have been piloting a new approach aimed at improving the timeliness of responses. Under the new arrangements all complaints have a 25-day timeframe unless they are identified as being complex, in which case the timeframe will be negotiated individually with the complainant. Extensions for the 25-day timeframe can also be agreed with complainants where necessary and appropriate. Divisional leads have been reminded of the need to allocate investigators promptly and increased quality checks by the complaints manager have enabled the chief executive to sign them off more quickly. In addition we have continued to encourage prompt informal resolution of concerns at team level wherever possible.

The evidence so far indicates that these proposals have had the desired effect with significant improvements in Quarters 3 and 4. They are therefore likely to be incorporated into policy.

The Trust previously arranged for the Patients Association to run a survey to monitor satisfaction with the way we handle complaints. Unfortunately levels of returns were too low to provide reliable data. We have therefore worked with Trust colleagues responsible for the Friends and Family Test to put together our own bespoke survey covering all formal complainants. We hope this will provide useful information to help us improve people's experience when they complain.

A key priority for next year is to roll out training for investigators. In the meantime the complaints team continues to provide one-to-one support to staff as required.

Compliance with NICE guidance

The National Institute of Clinical Excellence (NICE) produces guidance from the people who are affected by our work. This includes health and social care professionals, patients and the public in addition to guidance from the Department of Health. It is based on best evidence and designed to promote good health while preventing ill health.

Each month, new guidance released by NICE is circulated to the clinical directors for each division and other members of staff as considered appropriate. Any relevant guidelines (whether partial or completely relevant) are identified and a baseline assessment is completed to include an action plan to move the Trust towards compliance.

There are 59 guidelines that focus on mental health and are applicable to the Trust, but increasingly we also take into consideration physical health conditions including sepsis, diabetes and oral health.

The Trust is now fully compliant with 32 of the guidelines and is making good progress on the other 27 that have still to be completed. Currently only one guideline requires a lead and one baseline assessment is outstanding.

The table below illustrates the Trust's current compliance status on NICE guidelines from 2011 through to February 2017.

The Trust's current status on NICE guidelines 2011-Feb. 2017

Division	Guidelines Applicable from 2011 – 2017	Outstanding Baseline assessments	Partially Implemented	Completed
Acute	2	0	0	2
R&R	3	0	3	0
CMH	7	0	1	6
SAMH	10	1	2	7
SMS	4	0	0	4
Trust	33	0	20	13
Total	**59**	**1**	**26**	**32**

5.15 Quality initiatives in 2016/17

This section of the report describes the initiatives that teams and services have undertaken in the past year to improve the safety and effectiveness of care and the quality of the service user experience.

New psychiatric research database

The Trust can now research thousands of anonymised clinical records using a super database which has the potential to identify which treatments work best, where things don't and what can improve care.

The wide scope of the Clinical Record Interactive Search (CRIS) data, which includes data from other mental health trusts, makes the information far more meaningful and evidence-based when it comes to clinicians and policy makers making decisions about the most effective mental health services in the future.

C&I clinicians are currently working in collaboration with other trusts on several research projects, including:

- Identifying the key factors that increase the likelihood of patients relapsing and being admitted to acute mental health services, including A&E
- Examining the influence of environment on suicide and suicidal thoughts.

Identifying and supporting ex-servicemen in prison

The Trust has been collaborating through the London Veterans' Service (LVS) to help identify and improve the care of ex-servicemen who are in custody with mental health problems. The scheme has now been extended from Wandsworth prison to Brixton and Thameside prisons as well as Isis young offenders' institution.

In collaboration with veteran custody support officers our clinical nurse specialists are able to draw on a network of support to help these individuals both in prison and in the community when they have been released.

The project, run by the LVS, aims to reduce re-offending by ex-servicemen who get hooked into a pattern of criminal behaviour, often involving violence. It is estimated that between 3.5% and 17% of male prisoners are ex-servicemen.

Online therapy service for our Korean community

C&I psychological therapists and wellbeing specialists have developed an online therapy service which offers support to the area's large Korean population to try to break down the strong stigma many have about mental health.

A trainee psychological wellbeing practitioner will work with the service for a year to strengthen links with the community. The package will help educate local people of Korean background about what help is available and will encourage easier access.

One of the key themes in C&I's clinical strategy is making services available to all communities.

Drug resistant depression treatment

C&I is now offering an innovative new treatment to help individuals with drug-resistant depression.

The Transcranial Magnetic Stimulation device has been shown to increase recovery rates in patients who either cannot tolerate drug treatment or who have seen no improvement in their condition with the use of medication. In addition there are no systemic side-effects, unlike most drug treatments.

TMS uses a pulsating magnetic field to target specific sites in the brain, stimulating nerve cells in those areas, which helps to ease symptoms of depression. Treatment-resistant depression affects one-third of service users with depression and can blight people's lives.

For the initial stage of the service, the treatment is being limited to patients under the care of the Complex Depression Anxiety and Trauma Service.

Community talks reducing stigma around mental health

We recently set up a programme of community talks for adults in Islington to reduce stigma around mental health and help people access mental health services.

The project was organised by psychologists from the Trust and ran in 15 Islington primary schools as a series of coffee morning talks for parents on different topics, including helping people to think about the signs and symptoms of stress, low mood and worry.

The vast majority of parents said that after attending a talk they would seek help from C&I's Islington service, as well as recommend it to others – a view supported by the increase in referral numbers after the project began.

The project, run by the Trust's Islington iCope Psychological Therapies & Wellbeing Service, won a £10,000 prize in regional Health Education England Quality Awards to promote healthy living through education and training.

Crisis resolution teams win accreditation

The Trust's crisis resolution teams in Islington and North Camden have been endorsed by the Royal College of Psychiatry under its home treatment accreditation scheme.

The scheme supports services to improve and demonstrate the quality of care they provide. Information gathered through the accreditation process can be used in the Trust's quality accounts, as recommended by the National Quality Board.

Our crisis resolution and home treatment teams can provide an alternative to acute inpatient care. They also:

- Provide a service that responds rapidly and is intensive and time-limited
- Gate keep acute inpatient beds to prevent people being admitted who could be treated in the community
- Support early discharge of people who are admitted to acute inpatient services.

New simulation suite

The suite, which consists of a large simulation room with cameras, together with an adjoining observation studio, is available to trainee psychiatrists and other clinical staff. Staff are able, through simulation exercises, to develop their patient consultation and wider communication techniques as well as helping in preparing for clinical assessment exams.

The Trust has also recruited a Psychiatry Simulation Fellow to drive the project and is already running simulation training events with clinical staff.

Recovery College

The Trust continues to offer a range of free courses and workshops at its Recovery College in the grounds of St Pancras Hospital. The sessions are open to any adult from Camden and Islington – whether staff, user or member of the public.

All the courses are based on our recovery principles and topics include understanding mental and physical health conditions, wellbeing, building self-confidence and returning to work or study.

All our sessions – which have been running since 2014 - are created and delivered by two tutors, working together as equal partners, with one offering an expertise based on personal experience and the other based on professional expertise.

5.16 Additional Information as stipulated by NHS England

Implementation of duty of candour

Duty of candour is a key focus when investigations take place into incidents that have caused harm (severe and moderate harm). Lead investigators are trained to help patients receive accurate, truthful information from the Trust and to be open when errors have occurred. The computer software programme Datix has a function that records duty of candour for every incident that has occurred. It also makes clear to the user what duty of candour is.

In line with the quality priorities we have selected we will be focusing on improving communication with families and services users. The recent National Quality Board's new guidance to trusts on learning from deaths in particular asks that the needs of bereaved families be taken into account. We aim to ensure that bereaved families and carers:

- Should be treated as equal partners following a bereavement;
- Must always receive a clear, honest, compassionate and sensitive response in a sympathetic environment;
- Should receive a high standard of bereavement care which respects confidentiality, values, culture and beliefs. They should also be offered appropriate support, including providing, offering or directing people to specialist suicide bereavement support;
- Should be informed of their right to raise concerns about the quality of care provided to their loved one;
- Should help to inform decisions about whether a review or investigation is needed;
- Should receive timely, responsive contact and support in all aspects of an investigation process, with a single point of contact and liaison;
- Should be partners in an investigation to the extent that they wish to be involved since they offer a unique and equally valid source of information and evidence that can better inform investigations.
- In addition all bereaved families and carers who have experienced the investigation process should be supported, if they are willing, to work with Trusts to deliver training for staff on some of these issues.

Equality and Diversity, Staff Engagement and Organisational Development

Duty of candour is a key focus when investigations take place into incidents that have caused harm (severe and moderate harm). Lead investigators are trained to help patients receive accurate, truthful information from the Trust and to be open when errors have occurred. The computer software programme Datix has a function that records duty of candour for every incident that has occurred. It also makes clear to the user what duty of candour is.

Staff survey results

We set up and implemented divisional action plans to address some of the issues raised in the 2015 annual staff survey. The plans, which were supported by the Equality and Diversity, Staff Engagement, Organisational Development and Staff Side representatives, with additional help from the Network for Change (BME) coordinators, included a series of team away days to discuss issues around conflict and poor communication.

The Human Resources and Organisational Development Team continued to support the plans ahead of publication of the 2016 staff survey results.

KF26 - % of staff experiencing harassment and bullying from other staff

The Trust performance against this indicator is shown in the table below. Our 2016 scores are in line with the national average for mental health trusts.

2016	21%
2015	22%
2014	21%

We have a dedicated 'Freedom to Speak Up' guardian who is fully supported in their role to encourage staff to raise concerns and also be a listening ear. This is a formal part of the Raising Concerns and Whistleblowing Policies.

In addition, the Trust is training staff to become mediators to help to resolve and improve working relationships before they develop into formal grievances or allegations of bullying and harassment. Our aim is for the mediators to be trained by May 2017 and we will monitor the impact over the coming year.

KF21 - % believing that they have equal opportunity for career progression and promotion

The table below shows the Trust's performance which is significantly below the national average of 87% for mental health trusts and has declined from 2014.

2016	76%
2015	77%
2014	82%

The year on year results are similar. To address this ongoing issue, we have already implemented a number of interventions as part of the Our Staff First action plan.

The Network for Change was launched by staff from black and minority ethnic backgrounds in 2016 and is gaining momentum. Members from the network have been trained to sit on recruitment panels for Band 8a roles and above. This is already in operation for all senior roles and will be monitored.

The network will be a confidential space for staff to raise concerns around bullying and harassment and receive support and advice from fellow members.

We will also implement the following initiatives over the coming year:

- Unconscious bias training for all recruiting managers
- Advertising roles on diversityjob.co.uk to attract and recruit more BME applicants into senior positions
- Career clinics
- Leadership Development Programmes to develop staff from bands 6a
- A new NHS Diversity Training e-learning package for all staff
- E-learning advice on completing applications and interview skills training, backed up by face-to-face coaching.

In addition, all staff in Band 7 posts and above will be offered coaching to apply for senior posts within the Trust.

5.17 NHS Improvement Targets

In 16/17 the Trust continued to be assessed on a quarterly basis to meet selected national standards for access and outcomes. From April 2016 NHS improvement became the operational name that brings together Monitor and the NHS Trust Development Authority (TDA) Accountability Framework.

In October 2016 the Single Oversight Framework replaced Monitor's Risk and Assessment Framework, one of the main goals was to reduce information burden and ensure performance data is collected centrally scaling down data "industry". The framework assists NHSI across five themes and under the operational performance theme the indicators relate to one or more facets of quality (i.e. safe, effective and caring and/or responsive). Trust performance against these indicators is provided below.

Risk Assessment Framework

Service Performance Target	Target	Q1 Performance	Q2 Performance
Care Programme Approach (CPA) service users receiving follow-up contact within seven days of discharge from hospital	95%	95.8%	95.1%
CPA service users receiving formal review in the last 12 months	95%	96.6%	96.0%
Admissions to inpatient services had access to crisis resolution home treatment teams	95%	99.6%	100%
Minimised delayed transfers of care	<7.5%	1.4%	3.6%
Number of new cases of psychosis served by EIS	95%	100%	100%
People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral	50%	77.3%	79.1%
Improving access to psychological services (IAPT) a) People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral b) People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral	 75% 95%	 81.7% 98.9%	 82.1% 99.2%
Mental Health Data Completeness: – Identifiers	97%	97%	97.5%
Mental Health Data Completeness: – Outcomes for patients on CPA	50%	88%	87.5%
Learning disability access criteria	Compliance with the 6 learning disability criteria	Assurance provided via LD Annual reports to Board.	Assurance provided via LD Annual reports to Board.

Single Oversight Framework

Service Performance Target	Target	Q1 Performance	Q2 Performance
Care Programme Approach (CPA) service users receiving follow-up contact within seven days of discharge from hospital	95%	96.0%	96.3%
CPA service users receiving formal review in the last 12 months	95%	95.9%	96.1%
Admissions to inpatient services had access to crisis resolution home treatment teams	95%	99.2%	100%
People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral	50%	96.1%	87.5%
MHSDS: Identifier metrics	95%	97.4%	97.0%
MHSDS: Priority metrics	85%	88.9%	89.7%

Service Performance Target – Improving Access to Psychological Therapies (IAPT)	Target	Q1 Performance	Q2 Performance
Proportion of people completing treatment who move to recovery:			
Camden	50%	49.0%	50.9%
Islington		49.8%	49.3%
Kingston		52.8%	53.3%
People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral:			
Camden	75%	82.4%	84.5%
Islington		81.8%	87.2%
Kingston		94.9%	94.8%
People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral:			
Camden	95%	98.8%	98.0%
Islington		99.1%	98.8%
Kingston		99.0%	99.5%

Service users and staff on Sutherland Ward at St Pancras hold a cake sale for charity

5.18 Stakeholder involvement in Quality Accounts

The Trust's quality goals are co-developed with stakeholders and communicated within the Trust and the community it serves.

In order to finalise the selected Quality Priorities for 2017/18, the Trust carried out a survey to gather the views of patients, staff, volunteers, Members, Governors and other stakeholders on what they feel the Trust needs to focus on to ensure ongoing improvements to the quality of care. The information from this survey is used to inform the development of the Quality Account.

A "long list" of potential priorities was developed using a range of sources including: Quality and Safety scorecards, reports and groups (areas of underachievement and areas of focus for coming year) including:

- Governance and management leads and groups
- Feedback received through user forums during the year
- Commissioner feedback
- Stakeholder event

5.19 Stakeholder Statements

Commissioners' Statement for Camden and Islington Foundation Trust 16/17 Quality Accounts

NHS Islington Clinical Commissioning Group (CCG) is responsible for the commissioning of health services from Camden and Islington NHS Foundation Trust (CIFT) on behalf of the population of Islington and surrounding boroughs. NHS Islington Clinical Commissioning Group welcomes the opportunity to provide this statement on the Trust's Quality Account.

We confirm that we have reviewed the information contained within the Account. We have checked the information against data sources available to us, as part of existing contract/performance monitoring discussions, and that the information presented is accurate in relation to the services provided. We feel that the account provides a comprehensive summary of the work carried out by the Trust in 2016/17 to improve the safety, patient experience and outcomes of its service.

The priorities taken forward in 2016/17 focused on:

- *Improvement of mortality and morbidity review process.*
- *Learning from serious incidents*
- *Promotion of safe and therapeutic ward environments by preventing violence, reducing restraints and supporting staff and patients following assault incidents.*
- *Reduction of domestic violence and abuse.*
- *Increase service users and carers involvement in the implementation of the clinical strategy.*
- *Improvement of information given to service users about their medication.*
- *Reduction of non-clinical ward transfers.*
- *Improvement of compliance with the 18 weeks referral to treatment targets.*
- *Evidence based outcomes for the Integrated Practice Unit for Psychosis.*
- *Increase in the uptake of smoking cessation and promotion of a healthier lifestyle.*
- *Improve outcomes of the specialist care pathway.*
- *Increase staff knowledge and understanding of the Mental Capacity Act.*

We confirm that the Account complies with the prescribed information, form and content as set out by the Department of Health and represents a fair and balanced overview of the quality of care at CIFT. We also note the work that the Trust has undertaken to address the recommendations made in the latest CQC inspection report whilst continuing its focus on the quality priorities set for 2016/17.

The CCG looks forward to working with the Trust as it implements the ambitious quality priorities set for 2017/18 and is keen to work with the Trust to ensure sustained improvements in safety, patient experience and clinical effectiveness and better involvement and communication with families of people with mental illness.

Alison Blair
Accountable Officer
NHS Islington Clinical Commissioning Group

Received by the Trust 12 May 2017

The Trust would like to thank commissioners for their response and comments and helpful feedback on the report. We look forward look forward to working with them on quality and safety in the forthcoming year.

Comments from Healthwatch Camden, incorporating comments from Camden Health and Adult Social Care Scrutiny Committee

As a provider that was rated as Requires Improvement by CQC in 2016, the Trust clearly had a lot to do to improve quality. We welcome the open way they have approached this challenge. We note that during 2016 the Trust held an extensive consultation with the service users, their carers and relatives and other stakeholders, to form a long list of priorities from which a public vote produced nine quality indicators, which form the basis of the Trusts Quality Assurance Programme. We welcome the public involvement in setting priorities. We recognise that as this is the first year they are work in progress; they are ambitious and require a great deal of management effort as well as staff training.

We have a number of observations about specific priorities:

Patient Safety

It is welcome that improvement has been made in the number of prone restraints and there are good plans to reduce this further.

Risk assessment

We note that updated training for staff for clinical risk assessment is currently under review and will be finalised this year. We think there is much work to be done in this area as well as learning the lessons from serious incidents.

Health outcomes for people with serious mental illness

We would like to see real progress in the consistent recording and measurement of physical health in the patient records, working with the GP and helping those who do not have a GP to register, and regular audits to measure care plans and progress.

Suicide prevention strategies

We welcome the trust's Suicide Prevention Strategy, and their ambition to support those bereaved by suicide more.

Involving families

The issue of communication and involvement with families has been flagged as a problem area both by the CQC report and in Healthwatch Camden open meetings. So we welcome the plan to be more consistent with recording the details of next of kin as well as the service user's wishes of who to contact and communicate.

Emergency care

Effective action on improving the environment in the Accident and Emergency department will require a productive partnership with acute trusts; we look forward to learning of progress on this important area of care.

Care plans

The trust has an established system for involving people in their own care plans, and we welcome the initiative by the Practice Development Team to produce more tailored care plans around the individual.

Safeguarding

We were concerned that CQC found gaps in staff understanding of the Mental Capacity Act and how the safeguarding processes work. This issue was also raised in the previous CQC inspection and it is disappointing that it remains a serious training issue for the staff, which will require audit. There is a great deal of work to be done in creating therapeutic ward environments and it is disappointing to see that the number of violent episodes has increased.

We are concerned that when staff were assaulted they were reluctant to want action taken; staff are entitled to feel safe, violent incidents can escalate. A new security post has been created which is obviously welcome but action should be taken and staff supported to do this.

There has been good progress on raising awareness and training to identify and prevent domestic abuse, those vulnerable to abuse need quick help and support if a tragedy is too be avoided so it was encouraging to note that the Trust has agreed to fund this project for a further 18months.

There is still much to do to keep patients safe but it is hoped that the five year quality plan will provide continuous improvement.

Improving outcomes

Local people had raised many concerns over bed availability. The increase in the number of their beds during April 2016 did enable the Trust to achieve their priority of reducing non-clinical ward transfers and transfers to hospital beds provided by other organisations. Moving away from staff they know was very unpopular for the patients so it is very good to see the progress made in achieving this priority.

Improving physical health by assessing physical health providing care packages for COPD and Diabetes as well as help with smoking cessation and substance abuse is a great step forward.

Learning Disability

Information given in the report states that all data available has been reviewed for this service as well as receiving regular quality updates. There is no sense that the Trust is engaging with the Transforming Care agenda, or that it has absorbed the lessons from the Mazars report, or that it makes particular efforts to engage people with a learning disability. This is a pity, as the rating of 'good' for these services suggests they are doing a lot of things well – it would be helpful to see this reflected in the Quality Account.

Working across the community

We would have liked to have seen more focus on collaborating with and reaching out to local residents and organisations, listening to, learning from and also spreading the Trust's good practice. We were disappointed that there was not a greater sense in the report that this was a priority for the Trust.

Note on content and style:

National audits: 6 of those were applicable to the Trust, figures were given for the Trust but no parameters for comparison given.

Received by the Trust 12 May 2017

The Trust would like to thank Healthwatch Camden and Camden Health and Adult Social Care Scrutiny Committee for their response and comments. We look forward look forward to working with them on quality and safety in the forthcoming year.

In response to its comments we have included additional information on Learning Disabilities in the Performance section of the Annual Report:

Learning Disabilities

C&I continued its successful partnership with Camden and Islington councils to provide integrated services for people with Learning Disabilities who have a mental illness, with 24 of our clinical staff working in these joint teams.

The Care Quality Commission rated our Learning Disabilities services in 2016 as good in all aspects of care, commenting that: "Patients and carers had a positive experience of care, staff treated patients with care, compassion and communicated well."

During 2016/17 both learning disabilities services have been focused on the "transforming care agenda" with its two key themes: taking action to bring people with severe learning disabilities home from out of long term hospital care, and using. At Risk of Admission registers/urgent multi-agency planning processes to avoiding psychiatric hospital admission for this group whenever possible.

Lead Governor's comment on the Quality Report

I can confirm that as part of the processes involved in the production of this report I met with the Head of Governance and Quality Assurance, who confirmed to me that the priorities selected this year, a smaller and more manageable set than last year, did take into account issues raised by Commissioners, the CQC and Service Users. Moreover Governors were directly involved by way of the Service User and Staff experience sub group of the Governors. (There are a number of sub groups of the Council of Governors. They focus on different topics with different terms of reference: all Governors are required to serve on at least one group. Groups are chaired by a Governor and attended by the relevant NED. Groups are rather smaller than a full meeting of the Council, consist of Governors who have selected themselves for the group due to a particular interest or expertise, and are able to give topics detailed scrutiny in a way a plenary meeting of the Council of Governors would normally not attempt. The Service User and Staff Experience Group is seen as the appropriate one to deal with the Quality accounts.) In addition an open stakeholder event was held in February 2017 which all Governors were free to attend. In any case I am satisfied that the opportunities available to Governors to participate in the process were sufficient to fulfill relevant statutory obligations.

David Barry
Lead Governor
17 May 2017

Received by the Trust 17 May 2017

The Trust would like to thank the lead governor for the response and comments and look forward to working with governors on quality and safety in the forthcoming year.

Feedback

If you would like to give any feedback on the Quality Accounts 2015/16, suggest measures for 2016/17, or to ask questions, please contact the Governance and Quality Assurance Team. The team can be contacted by email at **governanceandquality.assurance@candi.nhs.uk**.

If you would like to give feedback on services at Camden & Islington Foundation Trust, please contact **feedback@candi.nhs.uk** or call **020 3317 3117**.

Annex1: Statement of the Directors' responsibility for the Quality Report

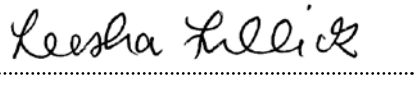
The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

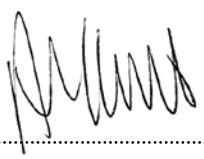
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2016 to May 2017
  - papers relating to quality reported to the board over the period April 2016 to May 2017
  - feedback from commissioners dated 12 May 2017
  - feedback from governors dated 17 May 2017
  - feedback from local Healthwatch organisations dated 12 May 2017
  - feedback from Overview and Scrutiny Committee dated 12 May 2017
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 18 May 2017
  - the national patient survey October 2016
  - the national staff survey 2016
  - the Head of Internal Audit's annual opinion of the Trust's control environment dated 26 May 2017
  - CQC inspection report dated June 2016
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.



Chair
26 May 2017



Chief Executive
26 May 2017

Annex 2: Independent auditor's report to the Council of Governors of Camden and Islington NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Camden and Islington NHS Foundation Trust to perform an independent assurance engagement in respect of Camden and Islington NHS Foundation Trust's quality report for the year ended 31 March 2017 (the 'Quality Report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the Council of Governors of Camden and Islington NHS Foundation Trust as a body, to assist the Council of Governors in reporting Camden and Islington NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2017, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Camden and Islington NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement (NHSI):

- Care Programme Approach 7 day follow up
- Access to Crisis Resolution Home Treatment Team (gatekeeping)

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual' issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in section 2.1 of the NHS Improvement 2016/17 Detailed guidance for external assurance on quality reports; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and supporting guidance and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with:

- board minutes for the period April 2016 to March 2017;
- papers relating to quality reported to the board over the period April 2016 to 31 March 2017;
- feedback from the Commissioners dated 12 May 2017;
- feedback from the governors dated 17 May 2017;

- feedback from local Healthwatch organisations dated 12 may 2017;
- feedback from Overview and Scrutiny Committee, dated 12 May 2017;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 18 May 2017;
- the latest national patient survey dated October 2016;
- the latest national staff survey dated 2016;
- Care Quality Commisssion inspection dated June 2016;
- the Head of Internal Audit's annual opinion over the trust's control environment dated 15 May 2017; and
- any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual' to the categories reported in the quality report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

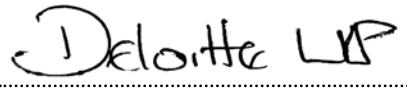
The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance.

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in 2.1 of the NHS Improvement 2016/17 Detailed guidance for external assurance on quality reports; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and supporting guidance.



Deloitte LLP
Chartered Accountants
Cardiff
26 May 2017

Acknowledgements

Camden & Islington NHS Foundation Trust would like to thank all the staff, service users and partner organisations that contributed to this report.

6

Summary Financial Statements

6.1 Statement of comprehensive income 2016/17

	2016/17 £000	2015/16 £000
Operating Income from Continuing Operations	139,187	138,153
Operating Expenses of Continuing Operations	(135,402)	(136,131)
OPERATING SURPLUS	3,785	2,022
Finance Costs		
Interest Receivable	101	174
Interest Payable	0	0
Other Finance Costs - Unwinding of Discount	(3)	(7)
Other Finance Costs - Change in Discount Rate on Provisions	0	0
PDC Dividends Payable	(3,971)	(3,867)
NET FINANCE COSTS	(3,873)	(3,700)
SURPLUS FOR THE YEAR	**(88)**	(1,678)
Other Comprehensive Income		
Impairments	(923)	(14,372)
Revaluations	1,372	6,942
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD	361	(9,108)

6.2 Statement of financial position as at 31 March 2017

	as at 31 March 2017 £000	as at 31 March 2016 £000
Non-Current Assets		
Intangible Assets	0	0
Property, Plant and Equipment	121,453	123,117
Investments	0	0
Trade and Other Receivables	0	0
Total Non-Current Assets	121,453	123,117
Current Assets		
Stocks and Work in Progress	0	0
Trade and Other Receivables	9,644	12,171
Investments	0	0
Non-current assets held for sale and assets in disposal groups	1,000	0
Cash and Cash Equivalents	44,526	41,139
Total Current Assets	55,170	53,310
Current Liabilities		
Trade and Other Payables	(22,336)	(21,922)
Provisions	(209)	(868)
Other Liabilities	(81)	0
Total Current Liabilities	**(22,626)**	(22,790)
TOTAL ASSETS LESS CURRENT LIABILITIES	**153,997**	153,637
Non-Current Liabilities		
Trade and Other Payables	0	0
Provisions	(48)	(49)
Other Liabilities	0	0
Total Non-Current Liabilities	**(48)**	(49)
TOTAL ASSETS EMPLOYED	**153,949**	153,588
FINANCED BY:		
Taxpayers Equity		
Public Dividend Capital	60,348	60,348
Revaluation Reserve	52,640	59,191
Donated Asset Reserve	0	0
Government Grant Reserve	0	0
Other Reserves	0	0
Income and Expenditure Reserve	41,961	41,049
TOTAL TAXPAYERS EQUITY	**153,949**	153,588

Prior year financial statements and corresponding notes have been restated to reflect a reclassification of credit balances to offset against related debtor balances that was previously included within other payables (£1.7m) and accruals (£1.7m). As the result of reclassification, in the statement of financial position, the trade and other receivables decreased from £13.9m to £12.1m and the trade and other creditors decreased from £23.7m to £22.0m.

6.3 Statement of changes in taxpayers' equity 2016/17

	2016/17 £000	2015/16 £000
Taxpayers' Equity at 1 April 2016	153,588	161,881
Surplus/(deficit) for the Year	(88)	(1,678)
Revaluation (Losses) Property, Plant and Machinery	(923)	(14,372)
Revaluation Gains Property, Plant and Machinery	1,372	6,942
Public dividend capital received	0	815
Taxpayers' Equity at 31 March 2017	**153,949**	153,588

6.4 Statement of cash flows 2016/17

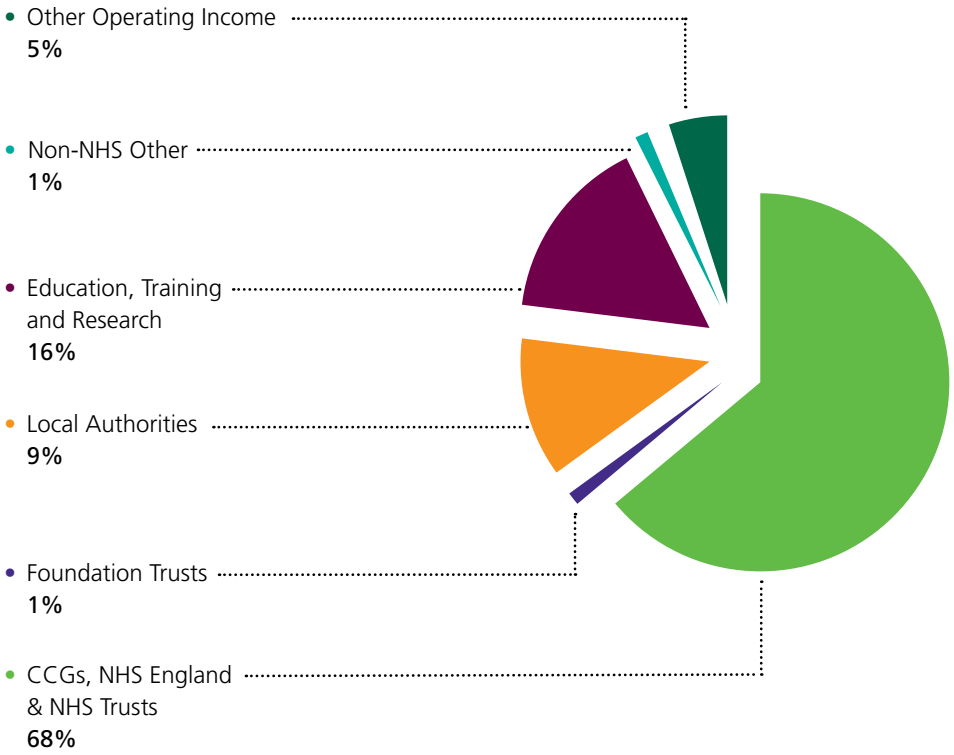
	2016/17 £000	2015/16 £000
CASH FLOWS FROM OPERATING ACTIVITIES		
Operating Surplus from Continuing Operations	3,785	2,022
OPERATING SURPLUS	3,785	2,022
Non-Cash Income and Expense		
Depreciation and Amortisation Charge	4,780	4,363
Fixed Asset Impairments and Reversals	155	2,398
(Gain)/Loss on disposal	0	0
Transfer from Donated Asset Reserve	0	0
(Increase)/Decrease in Stocks	0	0
(Increase)/Decrease in Trade and Other Receivables	2,674	(1,961)
Increase/(Decrease) in Trade and Other Payables	1,065	(3,034)
Increase/(Decrease) in Other Liabilities	81	(1,013)
Increase/(Decrease) in Provisions	(663)	56
Tax (Paid)/Received	0	0
NET CASH GENERATED FROM/(USED IN) OPERATIONS	11,877	2,830
Cash Flows from Investing Activities		
Interest Received	99	178
Sale of Financial Assets	0	0
Purchase of Property, Plant and Equipment	(4,473)	(9,542)
Sale of Property, Plant and Equipment	0	0
Interest Element of Finance Leases	0	0
NET CASH GENERATED FROM/(USED IN) INVESTING ACTIVITIES	(4,374)	(9,364)
Cash Flows from Financing Activities		
Public Dividend Capital Received	0	815
Interest Paid	0	(1)
Public Dividend Capital Paid	(4,116)	(4,128)
NET CASH GENERATED FROM FINANCING ACTIVITIES	(4,116)	(3,314)
INCREASE/DECREASE IN CASH AND CASH EQUIVALENTS	3,387	(9,848)
Cash and Cash Equivalents at 1 April	41,139	50,987
CASH AND CASH EQUIVALENTS AT 31 MARCH	44,526	41,139

6.5 Income (by source) 2016/17

The Trust's income for the full year amounted to £139m, the majority coming from the CCGs and NHS England for the provision of patient activity.

	£'000
CCGs, NHS England & NHS Trusts	95,054
Foundation Trusts	1,861
Local Authorities	12,695
Education, Training and Research	22,353
Non-NHS Other	489
Other Operating Income	6,735
TOTAL	139,187

Income (by source) 2016/17

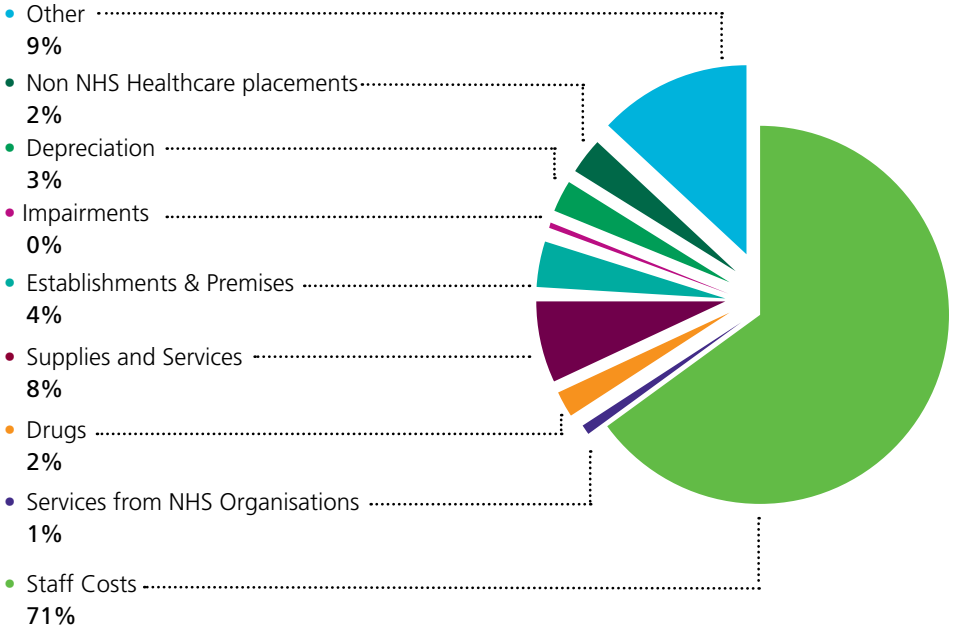


6.6 Expenditure (by type) 2016/17

Total operating expenditure for the year was £135m, the biggest item being spend on staff. The breakdown of the Trust's full expenditure is as follows:

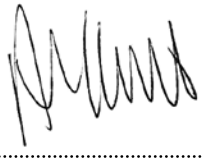
	£'000
Services from NHS Organisations	777
Staff Costs	95,647
Drugs	2,406
Non NHS Healthcare Placements	3,098
Supplies and Services	10,466
Establishment & Premises	5,140
Depreciation	4,780
Impairments	155
Other	12,933
TOTAL	135,402

Expenditure breakdown 2016/17



The summary statements are a summary of information derived from the Trust's annual accounts. Information to allow a full understanding of the Trust and of its policies and arrangements concerning directors' remuneration are provided by the full annual financial statements and report.

The statements were approved by the Board on 23 May 2017, following a recommendation from the Audit and Risk Committee, and signed on behalf of the Board by:



Angela McNab
Trust Chief Executive
26 May 2017

Independent Auditor's Statement to the Board of Governors and Board of Directors of Camden and Islington NHS Foundation Trust

We have examined:

- the summary financial statements contained within the Annual Report for the year ended 31 March 2017 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows; and
- the table of the single total figure for directors' remuneration contained within the Accountability Report

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of Camden and Islington NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not, in giving our opinion, accept or assume responsibility to anyone other than the Trust and the Boards, as a body, for this report, or for the opinions we have formed.

Respective responsibilities of directors and auditor

The directors are responsible for preparing the Annual Report (which includes the summary financial statements) and the supplementary material which includes the table of the single total figure for directors' remuneration in accordance with applicable United Kingdom law.

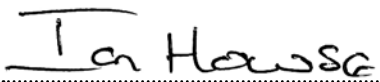
Our responsibility is to report to you our opinion on the consistency of the summary financial statements contained within the Annual Report with the full annual financial statements and our opinion on the consistency of the table of the single total figure for directors' remuneration contained within the Accountability Report with that table in the Directors' Remuneration Report.

We also read the other information contained in the Performance Report and the Accountability Report and the supplementary material as described in the contents section of the Annual Report and consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with the summary financial statements.

We conducted our work in accordance with Bulletin 2008/3 issued by the Auditing Practices Board. Our report on the Trust's full annual financial statements describes the basis of our audit opinion on those financial statements, the Directors' Remuneration Report, the Performance Report and the Accountability Report.

Opinion

In our opinion the summary financial statements contained within the Annual Report are consistent with the full annual financial statements of the Trust for the year ended 31 March 2017 and the table of the single total figure for directors' remuneration contained within the Accountability Report is consistent with that table in the full Directors' Remuneration Report.



Ian Howse CPFA (Senior Statutory Auditor)
For on and behalf of Deloitte LLP
Cardiff
26 May 2017

Other disclosures

6.7 Income disclosure

Camden and Islington NHS Foundation Trust is able to confirm that it has met its requirement, stipulated by the NHS Act 2006 (as amended by the Health and Social Care Act 2012), that the income the Trust has received from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purposes.

6.8 Cost allocation

The Trust has ensured that the financial statements of the organisation have met the accounting requirements of the NHS Trust Financial Reporting Manual. The accounting policies contained in both manuals follow International Financial Reporting Standards (IFRS) and HM Treasury's Resource Accounting Manual to the extent that they are meaningful and appropriate to the NHS.

6.9 Commissioner requested services

During 2016/17, the Trust recognised £110,099k of income from activities. Of this amount £90,404k related to Commissioner Requested Services and £19,685k related to Non-commissioner Requested Services.

6.10 Going concern disclosure

After making enquiries, the directors have a reasonable expectation that the NHS foundation trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

6.11 Pensions

This note discloses the number and additional pension costs for individuals who retired early on ill-health grounds during the year. There were no retirements in 2016/17.

(This information has been supplied by NHS Pensions)

Camden and Islington NHS Foundation Trust

Annual accounts for the year ended 31 March 2017

Foreword to the accounts

Camden and Islington NHS Foundation Trust

These accounts, for the year ended 31 March 2017, have been prepared by Camden and Islington NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed ……

Name **Angela McNab**
Job title **Chief Executive**
Date **26 May 2017**

Statement of Comprehensive Income

	Note	2016/17 £000	2015/16 £000
Operating income from patient care activities	3	110,099	107,481
Other operating income	4	29,088	30,672
Total operating income from continuing operations		**139,187**	**138,153**
Operating expenses	5.1, 7	(135,402)	(136,131)
Operating surplus/(deficit) from continuing operations		**3,785**	**2,022**
Finance income	10	101	174
Finance expenses	11	(3)	(7)
PDC dividends payable		(3,971)	(3,867)
Net finance costs		**(3,873)**	**(3,700)**
Gains/(losses) on disposal of non-current assets	12	-	-
Share of profit of associates/joint arrangements	20	-	-
Gains/ (losses) arising from transfers by absorption	43	-	-
Movement in the fair value of investment property and other investments	19, 21	-	-
Corporation tax expense	13	-	-
Surplus/(deficit) for the year from continuing operations		**(88)**	**(1,678)**
Surplus/(deficit) on discontinued operations and the gain/(loss) on disposal of discontinued operations	14	**-**	**-**
Surplus/(deficit) for the year		**(88)**	**(1,678)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	(923)	(14,372)
Revaluations	18	1,372	6,942
Share of comprehensive income from associates and joint ventures	20	-	-
Other recognised gains and losses		-	-
Remeasurements of the net defined benefit pension scheme liability/asset	37	-	-
Other reserve movements		-	-
May be reclassified to income and expenditure when certain conditions are met:			
Fair value gains/(losses) on available-for-sale financial investments	19	-	-
Recycling gains/(losses) on available-for-sale financial investments	10	-	-
Total comprehensive income/(expense) for the period		**361**	**(9,108)**

Statement of Financial Position

	Note	31 March 2017 £000	31 March 2016 (restated) £000
Non-current assets			
Intangible assets	15	-	-
Property, plant and equipment	16.1	121,453	123,117
Investment property	19	-	-
Investments in associates (and joint ventures)	19	-	-
Other investments	19	-	-
Trade and other receivables	24	-	-
Other financial assets	26	-	-
Other assets	25	-	-
Total non-current assets		**121,453**	**123,117**
Current assets			
Inventories	23	-	-
Trade and other receivables	24	9,644	12,171
Other financial assets	26	-	-
Non-current assets for sale and assets in disposal groups	27	1,000	-
Cash and cash equivalents	28	44,526	41,139
Total current assets		**55,170**	**53,310**
Current liabilities			
Trade and other payables	29	(22,336)	(21,922)
Other liabilities	31	(81)	-
Borrowings	32	-	-
Other financial liabilities	30	-	-
Provisions	34	(209)	(868)
Liabilities in disposal groups	27	-	-
Total current liabilities		**(22,626)**	**(22,790)**
Total assets less current liabilities		**153,997**	**153,637**
Non-current liabilities			
Trade and other payables	29	-	-
Other liabilities	31	-	-
Borrowings	32	-	-
Other financial liabilities	30	-	-
Provisions	34	(48)	(49)
Total non-current liabilities		**(48)**	**(49)**
Total assets employed		**153,949**	**153,588**
Financed by			
Public dividend capital		60,348	60,348
Revaluation reserve		52,640	52,191
Available for sale investments reserve		-	-
Other reserves		-	-
Merger reserve		-	-
Income and expenditure reserve		40,961	41,049
Total taxpayers' equity		**153,949**	**153,588**

Prior year financial statements and corresponding notes have been restated to reflect a reclassification of credit balances to offset against related debtor balances that were previously included within other payables (£1.7m) and accruals (£1.7m). As the result of reclassification, in the statement of financial position, the trade and other receivables decreased from £13.9m to £12.1m and the trade and other creditors decreased from £23.7m to £22.0m. The reclassification caused relevant changes in the following notes: 24.1, 24.2, 24.3, 29.1, 40.2, 40.3, 40.4 and 47.

The notes on pages 17 to 51 form part of these accounts.

Signed ……

Name **Angela McNab**
Position **Chief Executive**
Date **26 May 2017**

Statement of Changes in Equity for the year ended 31 March 2017

	Public dividend capital £000	Revaluation reserve £000	Available for sale investment reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2016 - brought forward	**60,348**	**52,191**	**-**	**41,049**	**153,588**
At start of period for new FTs	**-**	**-**	**-**	**-**	**-**
Surplus/(deficit) for the year	-	-	-	(88)	**(88)**
Transfers by absorption: transfers between reserves	-	-	-	-	**-**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	-	**-**
Other transfers between reserves	-	-	-	-	**-**
Impairments	-	(923)	-	-	**(923)**
Revaluations	-	1,372	-	-	**1,372**
Transfer to retained earnings on disposal of assets	-	-	-	-	**-**
Share of comprehensive income from associates and joint ventures	-	-	-	-	**-**
Fair value gains/(losses) on available-for-sale financial investments	-	-	-	-	**-**
Recycling gains/(losses) on available-for-sale financial investments	-	-	-	-	**-**
Other recognised gains and losses	-	-	-	-	**-**
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	-	**-**
Public dividend capital received	-	-	-	-	**-**
Public dividend capital repaid	-	-	-	-	**-**
Public dividend capital written off	-	-	-	-	**-**
Other movements in public dividend capital in year	-	-	-	-	**-**
Other reserve movements	-	-	-	-	**-**
Taxpayers' and others' equity at 31 March 2017	**60,348**	**52,640**	**-**	**40,961**	**153,949**

Statement of Changes in Equity for the year ended 31 March 2016

	Public dividend capital £000	Revaluation reserve £000	Available for sale investment reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2015 - brought forward	**59,533**	**59,621**	**-**	**42,727**	**161,881**
Prior period adjustment	-	-	-	-	**-**
Taxpayers' and others' equity at 1 April 2015 - restated	**59,533**	**59,621**	**-**	**42,727**	**161,881**
At start of period for new FTs	**-**	**-**	**-**	**-**	**-**
Surplus/(deficit) for the year	-	-	-	(1,678)	**(1,678)**
Transfers by absorption: transfers between reserves	-	-	-	-	**-**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	-	**-**
Other transfers between reserves	-	-	-	-	**-**
Impairments	-	(14,372)	-	-	**(14,372)**
Revaluations	-	6,942	-	-	**6,942**
Transfer to retained earnings on disposal of assets	-	-	-	-	**-**
Share of comprehensive income from associates and joint ventures	-	-	-	-	**-**
Fair value gains/(losses) on available-for-sale financial investments	-	-	-	-	**-**
Recycling gains/(losses) on available-for-sale financial investments	-	-	-	-	**-**
Other recognised gains and losses	-	-	-	-	**-**
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	-	**-**
Public dividend capital received	815	-	-	-	**815**
Public dividend capital repaid	-	-	-	-	**-**
Public dividend capital written off	-	-	-	-	**-**
Other movements in public dividend capital in year	-	-	-	-	**-**
Other reserve movements	-	-	-	-	**-**
Taxpayers' and others' equity at 31 March 2016	**60,348**	**52,191**	**-**	**41,049**	**153,588**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. Additional PDC may also be issued to NHS foundation trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Available-for-sale investment reserve
This reserve comprises changes in the fair value of available-for-sale financial instruments. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure

Merger reserve
This reserve reflects balances formed on merger of NHS bodies.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the NHS foundation trust.

Statement of Cash Flows

	Note	2016/17 £000	2015/16 (restated) £000
Cash flows from operating activities			
Operating surplus/(deficit)		3,785	2,022
Non-cash income and expense:			
Depreciation and amortisation	5.1	4,780	4,363
Net impairments	6	155	2,398
Income recognised in respect of capital donations	4	-	-
Amortisation of PFI deferred credit	4	-	-
Non-cash movements in on-SoFP pension liability		-	-
(Increase)/decrease in receivables and other assets		2,674	(1,961)
(Increase)/decrease in inventories		-	-
Increase/(decrease) in payables and other liabilities		1,146	(4,047)
Increase/(decrease) in provisions		(663)	56
Tax (paid)/received		-	-
Operating cash flows movement of discontinued operations		-	-
Other movements in operating cash flows		-	-
Net cash generated from/(used in) operating activities		**11,877**	**2,830**
Cash flows from investing activities			
Interest received		99	178
Purchase and sale of financial assets		-	-
Purchase of intangible assets		-	-
Sales of intangible assets		-	-
Purchase of property, plant, equipment and investment property		(4,473)	(9,542)
Sales of property, plant, equipment and investment property		-	-
Receipt of cash donations to purchase capital assets		-	-
Prepayment of PFI capital contributions		-	-
Investing cash flows of discontinued operations		-	-
Net cash generated from/(used in) investing activities		**(4,374)**	**(9,364)**
Cash flows from financing activities			
Public dividend capital received		-	815
Public dividend capital repaid		-	-
Movement on loans from the Department of Health		-	-
Movement on other loans		-	-
Capital element of finance lease rental payments		-	-
Capital element of PFI, LIFT and other service concession payments		-	-
Interest paid on finance lease liabilities		-	-
Interest paid on PFI, LIFT and other service concession obligations		-	-
Other capital receipts		-	-
Other interest paid		-	(1)
PDC dividend paid		(4,116)	(4,128)
Financing cash flows of discontinued operations		-	-
Cash flows from (used in) other financing activities		-	-
Net cash generated from/(used in) financing activities		**(4,116)**	**(3,314)**
Increase/(decrease) in cash and cash equivalents		**3,387**	**(9,848)**
Cash and cash equivalents at 1 April		**41,139**	**50,987**
Cash and cash equivalents at start of period for new FTs		**-**	**-**
Cash and cash equivalents transferred under absorption accounting	43	-	-
Cash and cash equivalents at 31 March	28.1	**44,526**	**41,139**

Notes to the Accounts

Note 1 Accounting policies and conventions

NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the *Department of Health Group Accounting Manual (DH GAM)* which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the *DH GAM 2016/17* issued by the Department of Health. The accounting policies contained in that manual follow IFRS and HM Treasury's Financial Reporting Manual (*FReM)* to the extent that they are meaningful and appropriate to the NHS. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

The Board of Directors considers the Trust's ability to continue to operate at a financially sound level for the subsequent 12 months. After making enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason,these accounts have been prepared on a going concern basis.

1.1 Consolidation

1.1.1 Subsidiaries

Subsidiary entities are those over which the foundation trust has the power to exercise control or a dominant influence so as to gain economic or other benefits. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines.

The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year (except where a subsidiary's financial year end is before 1 January or after 1 July in which case the actual amounts for each month of the foundation trust's financial year are obtained from the subsidiary and consolidated). Where subsidiaries' accounting policies are not aligned with those of the foundation trust (including where they report under UK GAAP) then amounts are adjusted during consolidation where the differences are material. Subsidiaries which are classified as 'held for sale' are measured at the lower of their carrying amount and 'fair value less costs to sell'.

1.1.2 Associates

Associate entities are those over which the foundation trust has the power to exercise a significant influence. Associate entities are recognised in the foundation trust's financial statements using the equity method. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the foundation trust's share of the entity's profit or loss or other gains and losses (e.g. revaluation gains on the entity's property, plant and equipment) following acquisition. It is also reduced when any distribution e.g. share dividends are received by the foundation trust from the associate. Associates which are classified as held for sale are measured at the lower of their carrying amount and 'fair value less costs to sell'.

1.1.3 Joint ventures

Joint ventures are separate entities over which the Trust has joint control with one or more other parties. The meaning of control is the same as that for subsidiaries. Joint ventures are accounted for by consolidating the Trust's share of the transactions, assets, liabilities, equity and reserves of the entity.

1.1.4 Joint operations

Joint operations are activities which are carried on with one or more other parties but which are not performed through a separate entity. The foundation trust includes within its financial statements its share of the activities, assets and liabilities.

1.2 Income Recognition

Income in respect of services provided is recognised when performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is by way of block contracts with commissioners in respect of healthcare services.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.3 Expenditure on Employee Benefits

1.3.1 Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

1.3.2 Pension costs

NHS Pension Scheme
Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

Accounting Valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

Local Government Superannuation Scheme
Superannuation Scheme which is a defined benefit pension scheme. The foundation trust has agreed to be guided by the actuarial advice given to the London Borough of Islington with regard to the appropriate level of contribution it makes to the pension fund and accounts for this in year.

1.4 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.5 Property, Plant and Equipment

1.5.1 Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has a cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

1.5.2 Measurement

Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual.

The valuations of specialised operational buildings will be based upon a Modern Equivalent Asset. Non-specialised operational property and land for existing use purposes will be based on Existing Use Value. For non-operational properties including surplus land, the valuations are carried out at Market Value.

Assets in the course of construction are valued at cost and are valued by professional valuers as part of the five or three-yearly valuation or when they are brought into use.

Operational equipment is valued at net current replacement cost. Equipment surplus to requirements is valued at net recoverable amount.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of Property, plant and equipment are depreciated over their remaining useful economic lives on a straight-line basis, and in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Asset lives fall into the following ranges:
-Plant and Machinery: 5 - 15 years
-Transport Equipment: 7 years
- Information Technology: 3 - 8years
-Furniture and Fittings: 7 - 10 years

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the *DH GAM* , impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

1.5.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable i.e.:

- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.5.4 Donated assets

Donated and grant-funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant-funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.6 Private Finance Initiatives

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services. The finance cost is calculated using the implicit interest rate for the scheme.

The service charge is recognised in operating expenses and the finance cost is charged to Finance Costs in the Statement of Comprehensive Income.

1.7 Intangible assets

1.7.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
• the trust intends to complete the asset and sell or use it
• the trust has the ability to sell or use the asset
• how the intangible asset will generate probable future economic or service delivery benefits, e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
• the trust can measure reliably the expenses attributable to the asset during development.

Software
Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income-generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.8 Government grants

Government grants are grants from government bodies other than income from commissioners or NHS trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

1.9 Inventories

Inventories are valued at the lower of cost and net realisable value.

1.10 Cash, bank and overdrafts

Cash, bank and overdraft balances are recorded at the current values of these balances in the NHS foundation trust's cash book. These balances exclude monies held in the foundation trust's bank account belonging to patients (see "third party assets" below). Account balances are only set off where a formal agreement has been made with the bank to do so. In all other cases overdrafts are disclosed within creditors. Interest earned on bank accounts and interest charged on overdrafts is recorded as, respectively, "interest receivable" and "interest payable" in the period to which they relate. Bank charges are recorded as operating expenditure in the periods to which they relate.

The Trust manages its cash balances (net of loans and capital expenditure requirements) year-on-year, in order to maintain liquidity in line with planned levels. As a foundation trust, the Trust has no externally imposed cash or capital requirements.

1.11 Financial instruments and financial liabilities

1.11.1 Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

1.11.2 De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.11.3 Classification and measurement

Financial assets are categorised as 'fair value through income and expenditure', loans and receivables or 'available-for-sale financial assets'.

Financial liabilities are classified as 'fair value through income and expenditure' or as 'other financial liabilities'.

1.11.4 Financial assets and financial liabilities at 'fair value through income and expenditure'

Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges.

1.11.5 Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets. The foundation trust's loans and receivables comprise: current investments, cash and cash equivalents, NHS receivables, accrued income, 'other receivables'.

HM Treasury has concluded that PDC is not a financial instrument within the scope of IAS32 and as such the foundation trust continues to present this within 'Taxpayers' Equity' in the Statement of Financial Position.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

1.11.6 Available-for-sale financial assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. When items classified as 'available-for-sale' are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in 'finance costs' in the Statement of Comprehensive Income.

1.11.7 Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

1.11.8 Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices when available, or otherwise from either independent appraisals or discounted cash flows as appropriate.

1.11.9 Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly or through use of an allowance account/bad debt provision. The use of an allowance account/bad debt provision is only used to offset the loss when, and only when the allowance account/bad debt provision specifically relates to that financial asset.

1.12 Leases

1.12.1 Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS foundation trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

1.12.2 Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

1.12.3 Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land is treated as an operating lease.

1.13 Provisions

The NHS foundation trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published by HM Treasury.

1.13.1 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the foundation trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is disclosed in the notes to the accounts.

1.13.2 Non-clinical risk pooling

The foundation trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims, are charged to operating expenses when the liability arises.

1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in the notes to the accounts where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in the notes to the accounts, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.15 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.16 Value added tax

Most of the activities of the NHS foundation trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.17 Foreign exchange

The functional and presentational currencies of the Trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:
• monetary items (other than financial instruments measured at "fair value through income and expenditure") are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction, and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.18 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Foundation Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts, in accordance with the requirements of HM Treasury's Financial Reporting Manual.

1.19 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS foundation trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accruals basis with the exception of provisions for future losses.

Note 1.20 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.21 Transfers of functions to / from other NHS bodies / local government bodies

For functions that have been transferred to the trust from another NHS / local government body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition.

For property plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the trust has transferred to another NHS / local government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss / gain corresponding to the net assets / liabilities transferred is recognised within expenses / income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve.

Note 1.22 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2016/17.

Note 1.23 Standards, amendments and interpretations in issue but not yet effective or adopted

The *DH GAM* does not require the following Standards and Interpretations to be applied in 2016/17. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018/19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

• IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
• IFRS 15 Revenue from Contracts with Customers -– Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
• IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
• IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018.

The Trust does not believe that the above standards will have a material impact on the Trust.

Note 2 Operating segments

The Trust considers its' activities constitute a single segment since they are provided wholly in the UK, are subject to similar risks and rewards and all the assets are managed as one central pot.

The Trust therefore has no distinct and separate operating segments.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2016/17 £000	2015/16 £000
Mental health services		
Cost and volume contract income	3,483	3,704
Block contract income	93,921	90,151
Clinical partnerships providing mandatory services (including S75 agreements)	12,695	13,626
Clinical income for the secondary commissioning of mandatory services	-	-
Other clinical income from mandatory services	-	-
All services		
Additional income for delivery of healthcare services	-	-
Private patient income	-	-
Other clinical income	-	-
Total income from activities	**110,099**	**107,481**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2016/17 £000	2015/16 £000
CCGs and NHS England	93,277	89,717
Local authorities	12,695	13,626
Department of Health	-	-
Other NHS foundation trusts	1,861	1,870
NHS trusts	1,777	1,469
NHS other	-	-
Non-NHS: private patients	-	-
Non-NHS: overseas patients (chargeable to patient)	-	-
NHS injury scheme (was RTA)	-	-
Non NHS: other	489	799
Additional income for delivery of healthcare services	-	-
Total income from activities	**110,099**	**107,481**
Of which:		
Related to continuing operations	110,099	107,481
Related to discontinued operations	-	-

Note 3.3 Overseas visitors (relating to patients charged directly by the NHS foundation trust)

	2016/17 £000	2015/16 £000
Income recognised this year	-	-
Cash payments received in-year	-	-
Amounts added to provision for impairment of receivables	-	-
Amounts written off in-year	-	-

Note 4 Other operating income

	2016/17 £000	2015/16 £000
Research and development	2,353	2,925
Education and training	20,000	19,485
Receipt of capital grants and donations	-	-
Charitable and other contributions to expenditure	-	-
Non-patient care services to other bodies	-	-
Support from the Department of Health for mergers	-	-
Sustainability and Transformation Fund income	-	-
Rental revenue from operating leases	2,256	1,969
Rental revenue from finance leases	-	-
Amortisation of PFI deferred credits	-	-
Income in respect of staff costs where accounted on gross basis	721	668
Other income	3,758	5,625
Total other operating income	**29,088**	**30,672**
Of which:		
Related to continuing operations	29,088	30,672
Related to discontinued operations	-	-

**Included in Other Income above are estates recharges of £2,097k (2015/16: £4,577k).*

Note 4.1 Income from activities arising from commissioner requested services

Under the terms of its provider license, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2016/17 £000	2015/16 £000
Income from services designated (or grandfathered) as commissioner requested services	90,404	86,800
Income from services not designated as commissioner requested services	19,695	20,681
Total	**110,099**	**107,481**

Note 4.2 Profits and losses on disposal of property, plant and equipment

The Trust has not made any disposals during 2016/17 (2015/16: no disposals).

Note 5 Expenditure

Note 5.1 Operating expenses

	2016/17 £000	2015/16 £000
Services from NHS foundation trusts	294	547
Services from NHS trusts	483	488
Services from CCGs and NHS England	-	-
Services from other NHS bodies	-	-
Purchase of healthcare from non NHS bodies	3,098	4,434
Purchase of social care	-	-
Employee expenses - executive directors	723	705
Remuneration of non-executive directors	124	115
Employee expenses - staff	94,800	92,574
Supplies and services - clinical	228	189
Supplies and services - general	10,238	8,694
Establishment	897	1,160
Research and development	-	-
Transport	100	133
Premises	4,243	3,940
Increase/(decrease) in provision for impairment of receivables	(138)	53
Increase/(decrease) in other provisions	-	-
Change in provisions discount rate(s)	-	2
Inventories written down	-	-
Drug costs	2,406	2,318
Rentals under operating leases	335	352
Depreciation on property, plant and equipment	4,780	4,363
Amortisation on intangible assets	-	-
Net impairments	155	2,398
Audit fees payable to the external auditor		
audit services- statutory audit	76	76
other auditor remuneration (external auditor only)	-	-
Clinical negligence	483	464
Legal fees	332	396
Consultancy costs	384	603
Internal audit costs	90	94
Training, courses and conferences	691	626
Patient travel	338	405
Car parking & security	2	2
Redundancy	19	(214)
Early retirements	-	-
Hospitality	32	30
Publishing	-	-
Insurance	84	87
Other services, eg external payroll	534	264
Grossing up consortium arrangements	-	-
Losses, ex gratia & special payments	104	91
Other*	9,467	10,743
Total	**135,402**	**136,131**
Of which:		
Related to continuing operations	135,402	136,131
Related to discontinued operations	-	-

**Other expenditure includes £4,174k of costs relating to staff employed by local authorities but managed by the Trust as part of the delegated budgets (2015/16: £4,415k).*

Note 5.2 Other auditor remuneration

	2016/17 £000	2015/16 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	-	-
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	**-**	**-**

Note 5.3 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2016/17 or 2015/16.

Note 6 Impairment of assets

	2016/17 £000	2015/16 £000
Net impairments charged to operating surplus / (deficit) resulting from:		
Loss or damage from normal operations	-	-
Over specification of assets	-	-
Abandonment of assets in course of construction	-	-
Unforeseen obsolescence	-	-
Loss as a result of catastrophe	-	-
Changes in market price	6	1,712
Other	149	686
Total net impairments charged to operating surplus / (deficit)	**155**	**2,398**
Impairments charged to the revaluation reserve	923	14,372
Total net impairments	**1,078**	**16,770**

Note 7 Employee benefits

	2016/17 Total £000	2015/16 Total £000
Salaries and wages	**69,191**	67,849
Social security costs	**7,174**	5,534
Employer's contributions to NHS pensions	**8,627**	8,484
Pension cost - other	**-**	-
Other post-employment benefits	**-**	-
Other employment benefits	**-**	-
Termination benefits	**-**	-
Temporary staff (including agency)	**10,531**	11,412
Total gross staff costs	**95,523**	**93,279**
Recoveries in respect of seconded staff	**-**	-
Total staff costs	**95,523**	**93,279**
Of which		
Costs capitalised as part of assets		

Note 7.1 Retirements due to ill-health

During 2016/17 there were no early retirements from the trust agreed on the grounds of ill-health (2015/16: 2). The estimated additional pension liabilities of these ill-health retirements is £0k (2015/16: £29k).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 8 Pension costs

The Trust has no on-Statement of Financial Position pension schemes for the year ended 31 March 2017, or for the year ended 31 March 2016.

Note 9 Operating leases

Note 9.1 Camden and Islington NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Camden and Islington NHS Foundation Trust is the lessor.

	2016/17 £000	2015/16 £000
Operating lease revenue		
Minimum lease receipts	2,256	1,969
Contingent rent	-	-
Other	-	-
Total	**2,256**	**1,969**

	31 March 2017 £000	31 March 2016 £000
Future minimum lease receipts due:		
- not later than one year;	2,073	1,846
- later than one year and not later than five years;	6,826	2,959
- later than five years.	4,020	659
Total	**12,919**	**5,464**

Note 9.2 Camden and Islington NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Camden and Islington NHS Foundation Trust is the lessee.

	2016/17 £000	2015/16 £000
Operating lease expense		
Minimum lease payments	335	352
Contingent rents	-	-
Less sublease payments received	-	-
Total	**335**	**352**

	31 March 2017 £000	31 March 2016 £000
Future minimum lease payments due:		
- not later than one year;	352	188
- later than one year and not later than five years;	1,065	645
- later than five years.	453	25
Total	**1,870**	**858**
Future minimum sublease payments to be received	-	-

Note 10 Finance income

Finance income represents interest received on assets and investments in the period.

	2016/17	2015/16
	£000	£000
Interest on bank accounts	101	174
Interest on loans and receivables	-	-
Interest on impaired financial assets	-	-
Interest on available for sale financial assets	-	-
Interest on held-to-maturity financial assets	-	-
Fair value gains / (losses) on other financial assets held at fair value through income and expenditure	-	-
Recycling of gains / (losses) on available for sale financial instruments	-	-
Other	-	-
Total	**101**	**174**

Note 11.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2016/17	2015/16
	£000	£000
Interest expense:		
Loans from the Department of Health	-	-
Commercial loans	-	-
Overdrafts	-	-
Finance leases	-	-
Interest on late payment of commercial debt	-	-
Other	-	1
Main finance costs on PFI and LIFT scheme obligations	-	-
Contingent finance costs on PFI and LIFT scheme obligations	-	-
Total interest expense	**-**	**1**
Other finance costs	-	-
Total	**-**	**1**

Note 11.2 The late payment of commercial debts (interest) Act 1998

	2016/17	2015/16
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	-	1
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 12 Gains/losses on disposal/derecognition of non-current assets

	2016/17	2015/16
	£000	£000
Profit on disposal of non-current assets	-	-
Loss on disposal of non-current assets	-	-
Net profit/(loss) on disposal of non-current assets	**-**	**-**

Note 13 Corporation tax

Health service bodies, including foundation trusts, are exempt from tax on their principal health care income under section 519A ICTA 1988, but are liable for tax if they are carrying out significant commercial activities that are not part of core health care delivery. The Trust was not required to pay corporation tax during 2016/17 (2015/16: nil).

Note 14 Discontinued operations

The Trust had no discontinued operations during 2016/17 (2015/16: nil).

Note 15 Intangible assets - 2016/17

The Trust had no intangible assets in 2016/17 (2015/16: nil).

Note 16 Property, plant and equipment

Note 16.1 Property, plant and equipment - 2016/17

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2016 - brought forward	**27,855**	**97,241**	**317**	**83**	**14,983**	**3,749**	**144,228**
Transfers by absorption	-	-	-	-	-	-	**-**
Additions	-	235	3,073	-	447	67	**3,822**
Impairments	-	(1,109)	-	-	-	-	**(1,109)**
Reversals of impairments	-	-	-	-	-	-	**-**
Reclassifications	-	1,214	(1,840)	42	584	-	**-**
Revaluations	613	759	-	-	-	-	**1,372**
Transfers to/ from assets held for sale	(400)	(600)	-	-	-	-	**(1,000)**
Disposals / derecognition	-	-	-	-	-	-	**-**
Valuation/gross cost at 31 March 2017	**28,068**	**97,740**	**1,550**	**125**	**16,014**	**3,816**	**147,313**
Accumulated depreciation at 1 April 2016 - brought forward	**-**	**9,605**	**-**	**36**	**8,130**	**3,341**	**21,112**
Depreciation at start of period as FT	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Transfers by absorption	-	-	-	-	-	-	**-**
Provided during the year	-	2,987	-	17	1,664	112	**4,780**
Impairments	-	(31)	-	-	-	-	**(31)**
Reversals of impairments	-	-	-	-	-	-	**-**
Reclassifications	-	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	-	**-**
Transfers to/ from assets held for sale	-	-	-	-	-	-	**-**
Disposals/ derecognition	-	-	-	-	-	-	**-**
Accumulated depreciation at 31 March 2017	**-**	**12,561**	**-**	**53**	**9,794**	**3,453**	**25,861**
Net book value at 31 March 2017	**28,068**	**85,179**	**1,550**	**72**	**6,221**	**363**	**121,453**
Net book value at 1 April 2016	**27,855**	**87,636**	**317**	**47**	**6,854**	**408**	**123,117**

Note 16.2 Property, plant and equipment - 2015/16

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2015 - as previously stated	**41,112**	**84,720**	**2,939**	**62**	**10,652**	**3,742**	**143,227**
Valuation/gross cost at start of period as FT	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Transfers by absorption	-	-	-	-	-	-	**-**
Additions	-	1,793	6,990	-	811	7	**9,601**
Impairments	(13,408)	(2,134)	-	-	-	-	**(15,542)**
Reversals of impairments	-	-	-	-	-	-	**-**
Reclassifications	-	6,071	(9,612)	21	3,520	-	**-**
Revaluations	151	6,791	-	-	-	-	**6,942**
Transfers to/ from assets held for sale	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	-	**-**
Valuation/gross cost at 31 March 2016	**27,855**	**97,241**	**317**	**83**	**14,983**	**3,749**	**144,228**
Accumulated depreciation at 1 April 2015 - as previously stated	**-**	**6,171**	**-**	**25**	**6,098**	**3,227**	**15,521**
Depreciation at start of period as FT	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Transfers by absorption	-	-	-	-	-	-	**-**
Provided during the year	-	2,892	-	11	1,346	114	**4,363**
Impairments	-	542	-	-	686	-	**1,228**
Reversals of impairments	-	-	-	-	-	-	**-**
Reclassifications	-	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	-	**-**
Transfers to/ from assets held for sale	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	-	**-**
Accumulated depreciation at 31 March 2016	**-**	**9,605**	**-**	**36**	**8,130**	**3,341**	**21,112**
Net book value at 31 March 2016	**27,855**	**87,636**	**317**	**47**	**6,854**	**408**	**123,117**
Net book value at 1 April 2015	**41,112**	**78,549**	**2,939**	**37**	**4,554**	**515**	**127,706**

Note 16.3 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017							
Owned	28,068	85,179	1,550	72	6,221	363	**121,453**
Finance leased	-	-	-	-	-	-	**-**
On-SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	**-**
PFI residual interests	-	-	-	-	-	-	**-**
Government granted	-	-	-	-	-	-	**-**
Donated	-	-	-	-	-	-	**-**
NBV total at 31 March 2017	**28,068**	**85,179**	**1,550**	**72**	**6,221**	**363**	**121,453**

Note 16.4 Property, plant and equipment financing - 2015/16

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2016							
Owned	27,855	87,636	317	47	6,854	408	**123,117**
Finance leased	-	-	-	-	-	-	**-**
On-SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	**-**
PFI residual interests	-	-	-	-	-	-	**-**
Government granted	-	-	-	-	-	-	**-**
Donated	-	-	-	-	-	-	**-**
NBV total at 31 March 2016	**27,855**	**87,636**	**317**	**47**	**6,854**	**408**	**123,117**

Note 17 Donations of property, plant and equipment

The Trust had no donated assets in 2016/17 (2015/16: nil).

Note 18 Revaluations of property, plant and equipment

The Trust's freehold land and buildings are stated at their revalued amounts, being the fair value at the date of revaluation, less any subsequent accumulated depreciation and subsequent accumulated impairment losses. The fair value measurements of the Trust's freehold land and buildings were performed by the District Valuer (a professionally qualified, independent valuer not related to the Trust) during 2016/17. The valuation, undertaken as at 1st February 2017, conforms to International Valuation Standards and was based on recent market transactions on arm's length terms for similar properties. The fair value of the freehold land was determined based on the market comparable approach that reflects recent transaction prices for similar properties. The fair value of the buildings was determined using the cost approach that reflects the cost to a market participant to construct assets of comparable utility and age, adjusted for obsolescence.

The Trust recognises that it is currently considering the location of future bed provision and is actively engaged in the development of the strategic transformation plan for the North Central London sector. In light of this, the Trust has decided that it is no longer appropriate to base the replacement cost for its inpatient sites (at St Pancras Hospital and at Highgate) on the existing locations, and instead has decided that, from 2015/16, it is appropriate to base the valuations on an alternative site basis, allowing for a potential future re location across the North Central London sector. The District Valuer has taken this into consideration when preparing the valuations.

The impact of this exercise led to an impairment hit of £155k on the Trust's I&E and a net upwards revaluation of £449k which impacted on the Revaluation Reserve. The restated value of the assets is measured on a Modern Equivalent Asset basis.

Note 19 Investment property

Note 19.1 Investment property

The Trust had no investment property as at 31 March 2017 (31 March 2016: nil).

Note 19.2 Investment property income and expenses

The Trust had no investment property income or expenses as at 31 March 2017 (31 March 2016: nil).

Note 20 Investments in associates (and joint ventures)

The Trust had no investments in associates as at 31 March 2017 (31 March 2016: nil).

Note 21 Other investments

The Trust had no other investments as at 31 March 2017 (31 March 2016: nil).

Note 22 Disclosure of interests in other entities

The Trust had no interests in other entities during 2016/17 (2015/16: nil).

Note 23 Inventories

The Trust held no inventories as at 31 March 2017 (31 March 2016: nil).

Note 24 Receivables

Note 24.1 Trade receivables and other receivables

	31 March 2017 £000	31 March 2016 (restated) £000
Current		
Trade receivables due from NHS bodies	7,097	8,191
Receivables due from NHS charities	-	-
Other receivables due from related parties	1,455	2,749
Capital receivables	-	-
Provision for impaired receivables	(127)	(267)
Deposits and advances	-	-
Prepayments (non-PFI)	433	327
PFI prepayments:		
Capital contributions	-	-
Lifecycle replacements	-	-
Accrued income	92	200
Interest receivable	2	-
Corporation tax receivable	-	-
Finance lease receivables	-	-
Operating lease receivables	-	-
PDC dividend receivable	286	141
VAT receivable	342	288
Other receivables	64	543
Total current trade and other receivables	**9,644**	**12,171**
Non-current		
Trade receivables due from NHS bodies	-	-
Receivables due from NHS charities	-	-
Other receivables due from related parties	-	-
Capital receivables	-	-
Provision for impaired receivables	-	-
Deposits and advances	-	-
Prepayments (non-PFI)	-	-
PFI prepayments:		
Capital contributions	-	-
Lifecycle replacements	-	-
Accrued income	-	-
Interest receivable	-	-
Corporation tax receivable	-	-
Finance lease receivables	-	-
Operating lease receivables	-	-
VAT receivable	-	-
Other receivables	-	-
Total non-current trade and other receivables	**-**	**-**

Note 24.2 Provision for impairment of receivables

	2016/17 £000	2015/16 (restated) £000
At 1 April as previously stated	**267**	**227**
Prior period adjustments	-	-
At 1 April - restated	**267**	**227**
At start of period for new FTs	**-**	**-**
Transfers by absorption	-	-
Increase in provision	(138)	53
Amounts utilised	(2)	(13)
Unused amounts reversed	-	-
At 31 March	**127**	**267**

Note 24.3 Analysis of financial assets

	31 March 2017		31 March 2016 (restated)	
Ageing of impaired financial assets	**Trade and other receivables £000**	**Investments & other financial assets £000**	**Trade and other receivables £000**	**Investments & other financial assets £000**
0 - 30 days	4	-	116	-
30-60 Days	17	-	22	-
60-90 days	17	-	12	-
90- 180 days	9	-	32	-
Over 180 days	80	-	85	-
Total	**127**	**-**	**267**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	1,977	-	5,526	-
30-60 Days	1,186	-	290	-
60-90 days	900	-	954	-
90- 180 days	1,071	-	953	-
Over 180 days	3,255	-	3,130	-
Total	**8,389**	**-**	**10,853**	**-**

Note 25 Other assets

The Trust held no other assets as at 31 March 2017 (31 March 2016: nil).

Note 26 Other financial assets

The Trust held no other financial assets as at 31 March 2017 (31 March 2016: nil).

Note 27 Disposal groups

Note 27.1 Non-current assets for sale and assets in disposal groups

	2016/17				2015/16
	Intangible assets	Property, plant & equipment	Investment properties	Total	Total
	£000	£000	£000	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**-**	**-**	**-**	**-**	**-**
Prior period adjustment	-	-	-	-	**-**
NBV of non-current assets for sale and assets in disposal groups at 1 April - restated	**-**	**-**	**-**	**-**	**-**
At start of period for new FTs	**-**	**-**	**-**	**-**	**-**
Transfers by absorption	-	-	-	**-**	**-**
Plus assets classified as available for sale in the year	-	1,000	-	**1,000**	**-**
Less assets sold in year	-	-	-	**-**	**-**
Less impairment of assets held for sale	-	-	-	**-**	**-**
Plus reversal of impairment of assets held for sale	-	-	-	**-**	**-**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	-	-	-	**-**	**-**
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**1,000**	**-**	**1,000**	**-**

The Trust has formally declared Hanley Rd as an asset held for sale and intends to dispose of it in early 2017/18 (31 March 2016: no assets held for sale). The property is currently vacant and is deemed to be surplus to rquirements.

Note 27.2 Liabilities in disposal groups

The Trust had no liabilities in disposal groups as at 31 March 2017 (31 March 2016: nil)

Note 28 Cash and cash equivalents

Note 28.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2016/17	2015/16
	£000	£000
At 1 April	**41,139**	**50,987**
Prior period adjustments	-	-
At 1 April (restated)	**41,139**	**50,987**
At start of period for new FTs	**-**	**-**
Transfers by absorption	-	-
Net change in year	3,387	(9,848)
At 31 March	**44,526**	**41,139**
Broken down into:		
Cash at commercial banks and in hand	49	39
Cash with the Government Banking Service	44,477	41,099
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	**44,526**	**41,139**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**44,526**	**41,139**

Note 28.2 Third party assets held by the NHS foundation trust

Camden and Islington NHS Foundation Trust held cash and cash equivalents which relate to monies held by the the foundation trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2017	31 March 2016
	£000	£000
Bank balances	152	186
Monies on deposit	-	-
Total third party assets	**152**	**186**

Note 29 Payables

Note 29.1 Trade and other payables

	31 March 2017 £000	31 March 2016 (restated) £000
Current		
Receipts in advance	193	493
NHS trade payables	5,220	2,336
Amounts due to other related parties	3,850	4,496
Other trade payables	-	-
Capital payables	440	1,091
Social security costs	1,035	815
VAT payable	-	498
Other taxes payable	758	804
Other payables	3,346	2,453
Accruals	7,494	8,936
PDC dividend payable	-	-
Total current trade and other payables	**22,336**	**21,922**
Non-current		
Receipts in advance	-	-
NHS trade payables	-	-
Amounts due to other related parties	-	-
Other trade payables	-	-
Capital payables	-	-
VAT payable	-	-
Other taxes payable	-	-
Other payables	-	-
Accruals	-	-
Total non-current trade and other payables	**-**	**-**

Note 29.2 Early retirements in NHS payables above

	31 March 2017 £000	31 March 2017 Number	31 March 2016 £000	31 March 2016 Number
The payables note above includes amounts in relation to early retirements as set out below:				
- to buy out the liability for early retirements over 5 years	-	-	-	-
- number of cases involved	-	-	-	-
- outstanding pension contributions	-	-	-	-

Note 30 Other financial liabilities

	31 March 2017 £000	31 March 2016 £000
Current		
Derivatives held at fair value through income and expenditure	-	-
Other financial liabilities	-	-
Total	**-**	**-**
Non-current		
Derivatives held at fair value through income and expenditure	-	-
Other financial liabilities	-	-
Total	**-**	**-**

Note 31 Other liabilities

	31 March 2017 £000	31 March 2016 £000
Current		
Deferred grants income	-	-
Deferred goods and services income	81	-
Deferred rent of land income	-	-
Other deferred income	-	-
Deferred PFI credits	-	-
Lease incentives	-	-
Total other current liabilities	**81**	**-**
Non-current		
Deferred grants income	-	-
Deferred goods and services income	-	-
Deferred rent of land income	-	-
Other deferred income	-	-
Deferred PFI credits	-	-
Lease incentives	-	-
Net pension scheme liability	-	-
Total other non-current liabilities	**-**	**-**

Note 32 Borrowings

The Trust had no borrowings at 31 March 2017 (31 March 2016: nil).

Note 33 Finance leases

Note 33.1 Camden and Islington NHS Foundation Trust as a lessor

The Trust had no finance leases as a lessor at 31 March 2017 (31 March 2016: nil).

Note 33.2 Camden and Islington NHS Foundation Trust as a lessee

The Trust had no finance leases as a lessee at 31 March 2017 (31 March 2016: nil).

Note 34 Provisions and liabilities

Note 34.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Other legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2016	**67**	**97**	**200**	**553**	**917**
At start of period for new FTs	**-**	**-**	**-**	**-**	**-**
Transfers by absorption	-	-	-	-	**-**
Change in the discount rate	-	-	-	-	**-**
Arising during the year	-	24	-	86	**110**
Utilised during the year	(14)	(24)	(29)	(426)	**(493)**
Reclassified to liabilities held in disposal groups	-	-	-	-	**-**
Reversed unused	-	(12)	(171)	(97)	**(280)**
Unwinding of discount	3	-	-	-	**3**
At 31 March 2017	**56**	**85**	**-**	**116**	**257**
Expected timing of cash flows:					
- not later than one year;	8	85	-	116	**209**
- later than one year and not later than five years;	48	-	-	-	**48**
- later than five years.	-	-	-	-	**-**
Total	**56**	**85**	**-**	**116**	**257**

The Trust has made provisions for member contributions for provisions held by the NHS Litigation Authority, and for potential backpay and employment tribunal verdicts, which will be subject to independent, external assessment.

The amount included in provisions of the NHSLA in respect of clinical negligence liabilities relating to the Trust are, as at 31 March 2017, £1,073k (21 March 16: £1,180k).

These provisions are recorded in the books of the NHSLA.

Note 34.2 Clinical negligence liabilities

At 31 March 2017, £1,073k was included in provisions of the NHSLA in respect of clinical negligence liabilities of Camden and Islington NHS Foundation Trust (31 March 2016: £1,180k).

Note 35 Contingent assets and liabilities

	31 March 2017 £000	31 March 2016 £000
Value of contingent liabilities		
NHS Litigation Authority legal claims	-	-
Employment tribunal and other employee-related litigation	-	-
Redundancy	-	-
Other	-	-
Gross value of contingent liabilities	**-**	**-**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**-**	**-**
Net value of contingent assets	**-**	**-**

Note 36 Contractual capital commitments

	31 March 2017 £000	31 March 2016 £000
Property, plant and equipment	80	102
Intangible assets	-	-
Total	**80**	**102**

Note 37 Defined benefit pension schemes

The Trust contributes to the London Borough of Islington pension scheme for five individuals who were previously employed by the Borough, but who transferred to the Trust when the Trust took responsibility for the delegated activities.

The Trust expects to continue to contribute to the scheme in line with the actuarial advice supplied to London Borough of Islington with regard to the appropriate overall level of scheme contribution.

Note 37.1 Changes in the defined benefit obligation and fair value of plan assets during the year

The Trust contributes to the London Borough of Islington pension scheme for five individuals who were previously employed by the Borough, but who transferred to the Trust when the Trust took responsibility for the delegated activities.

Note 38 On-SoFP PFI, LIFT or other service concession arrangements

The Trust has no PFI (or other service concession arrangements) reported on the SoFP at 31 March 2017 (31 March 2016: nil).

Note 39 Off-SoFP PFI, LIFT and other service concession arrangements

The Trust has no PFI (or other service concession arrangements) reported off the SoFP at 31 March 2017 (31 March 2016: nil).

Note 40 Financial instruments

Note 40.1 Financial risk management

The majority of the Trust's financial instruments are held in the GBS accounts or on deposit with the National Loans Fund, and the majority of its financial liabilities are in the form of public dividend capital with the Department of Health. It is not deemed therefore, that the Trust faces material levels of risk in terms of its financial instruments.

The Trust's net operating costs are incurred under service agreement contracts with local CCGs, which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure through internally generated resources. The Trust is not, therefore, exposed to significant liquidity risks.

The Trust has no foreign currency income or expenditure. The Trust has minimal exposure to interest rate risk. The Trust makes no variable rate deposits and as at 31 March 2017, the Trust held all its cash in interest-bearing current accounts, and had no cash on deposit and no loans.

The Trust has negligible exposure to the risk of another party failing to discharge their obligations, as the parties that the Trust is contracted to are financed by resources voted on annually by Parliament. The Trust, therefore, is not subject to any material risk of being unable to deliver services.

Note 40.2 Financial assets

	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available-for-sale £000	Total £000
Assets as per SoFP as at 31 March 2017					
Trade and other receivables excluding non financial assets	8,925	-	-	-	**8,925**
Other investments	-	-	-	-	**-**
Other financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	44,526	-	-	-	**44,526**
Total at 31 March 2017	**53,451**	**-**	**-**	**-**	**53,451**

	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available-for-sale £000	Total £000
Assets as per SoFP as at 31 March 2016					
Trade and other receivables excluding non financial assets	11,704	-	-	-	**11,704**
Other investments	-	-	-	-	**-**
Other financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	41,139	-	-	-	**41,139**
Total at 31 March 2016 (restated)	**52,843**	**-**	**-**	**-**	**52,843**

Note 40.3 Financial liabilities

	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total £000
Liabilities as per SoFP as at 31 March 2017			
Borrowings excluding finance lease and PFI liabilities	-	-	**-**
Obligations under finance leases	-	-	**-**
Obligations under PFI, LIFT and other service concession contracts	-	-	**-**
Trade and other payables excluding non financial liabilities	20,350	-	**20,350**
Other financial liabilities	-	-	**-**
Provisions under contract	257	-	**257**
Total at 31 March 2017	**20,607**	**-**	**20,607**

	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total £000
Liabilities as per SoFP as at 31 March 2016			
Borrowings excluding finance lease and PFI liabilities	-	-	**-**
Obligations under finance leases	-	-	**-**
Obligations under PFI, LIFT and other service concession contracts	-	-	**-**
Trade and other payables excluding non financial liabilities	19,312	-	**19,312**
Other financial liabilities	-	-	**-**
Provisions under contract	917	-	**917**
Total at 31 March 2016 (restated)	**20,229**	**-**	**20,229**

Note 40.4 Maturity of financial liabilities

	31 March 2017 £000	31 March 2016 (restated) £000
In one year or less	20,559	20,180
In more than one year but not more than two years	12	7
In more than two years but not more than five years	36	20
In more than five years	-	23
Total	**20,607**	**20,229**

Note 40.5 Fair values of financial assets at 31 March 2017

	Book value £000	Fair value £000
Non-current trade and other receivables excluding non financial assets	-	-
Other investments	-	-
Other	-	-
Total	**-**	**-**

Note 40.6 Fair values of financial liabilities at 31 March 2017

	Book value £000	Fair value £000
Non-current trade and other payables excluding non financial liabilities	-	-
Provisions under contract	48	48
Loans	-	-
Other	-	-
Total	**48**	**48**

Note 41 Losses and special payments

	2016/17		2015/16	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	10	-	5	3
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	3	-	2	13
Stores losses and damage to property	1	-	-	-
Total losses	**14**	**-**	**7**	**16**
Special payments				
Extra-contractual payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Compensation payments	8	40	3	2
Special severence payments	1	2	-	-
Ex-gratia payments	22	16	14	4
Total special payments	**31**	**58**	**17**	**6**
Total losses and special payments	**45**	**58**	**24**	**22**
Compensation payments received				

Note 42 Gifts

	2016/17		2015/16	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Total gifts	**7**	**1**	**6**	**1**

Note 43 Transfers by absorption

There have been no prior period adjustments during 2016/17 (2015/16: nil).

Note 44 Prior period adjustments

The Trust has had no prior period adjustments during 2016/17 (2015/16: nil).

Note 45 Events after the reporting date

There have been no events after the reporting date.

Note 46 Final period of operation as a provider of NHS healthcare

The Trust is not in a final period of operation as a provider of NHS healthcare.

Note 47 Related parties

	Receivables (restated)		Payables (restated)	
	31 March 2017 £000	31 March 2016 £000	31 March 2017 £000	31 March 2016 £000
The Whittington Hospital NHS Trust	1,040	1,260	1,797	581
Camden CCG	1,027	2,321		
Islington CCG	581	1,228		
London Borough Camden	777	1,957	389	1,285
NHS Professionals			1,464	1,504
NHS Pensions			1,250	1,205
HM Revenue & Customs - Other taxes and duties and NI			1,793	1,619
Total	**3,425**	**6,766**	**6,693**	**6,194**

	Income		Expenditure	
	2016/17	2015/16 £000	2016/17 £000	2015/16 £000
Central and North West London NHS Foundation Trust	2,630	3,055	955	869
Royal Free London NHS Foundation Trust	1,938	1,710		
University College London Hospitals NHS Foundation Trust	1,013	1,021	1,059	1,181
The Whittington Hospital NHS Trust	2,210	1,384	1,276	673
Camden CCG	46,531	45,549		
Islington CCG	37,967	37,023		
Kingston CCG	2,895	1,931		
Health Education England	20,125	19,559		
Department of Health	1,359	2,049		
NHS Professionals			9,033	9,292
HM Revenue & Customs - Other taxes and duties and NI			7,174	5,534
NHS Pension Scheme (Own staff employers contributions only			9,233	9,106
Camden London Borough Council	6,864	7,967	2,530	2,913
Islington London Borough Council	7,072	7,081	1,909	2,005
Total	**130,604**	**128,329**	**33,169**	**31,573**

**The Trust has applied a de minimis limit of £1,000k (2016/17 only) for both tables in order to simplify presentation.*

Note 48 Pooled budgets

The Camden and Islington NHS Foundation Trust has a pooled budget arrangement with the London Borough of Islington. The pooled budget was established as at 1st April 2005 and is hosted by the Camden and Islington NHS Foundation Trust.

Pooled Budget Memorandum Account for 2016/17

	2016/17 £000	2015/16 £000
Income		
Foundation Trust	20,440	18,071
London Borough of Islington	3,144	3,127
	23,584	**21,198**
Expenditure		
Pay	22,180	21,248
Drugs	1,005	784
General Supplies and Services	193	153
Clinical Supplies and Services	93	79
Establishment	137	184
Premises & Fixed Plant	209	282
Other	533	298
	24,350	**23,028**
Net under / (over) spend	**-766**	**(1,830)**
	-3%	*-3%*

Note 49 Uncertainties

Under IAS 1, the Trust is required to make a disclosure of key areas where there are underlying judgements and estimates in the accounts.

The Trust was required to make a number of reasonable subjective judgements and estimates in the preparation of the accounts. The key judgements made regarded i) the valuation of property assets, which are based on a valuation undertaken by an independent valuer, and was prepared in accordance with the required standards, ii) the provisions for credit notes and impairments of receivables, which are based on management's judgement (and taking into account the national Agreement of Balances exercise and ongoing discussions with counter parties) regarding the best estimate of the amount expected to be not at risk and recoverable. The key estimates made regarded the calculation of accruals, which are based on management's best knowledge of likely revenue receipt and expenditure levels.

There has been no material change in estimational techniques, while significant judgements made in preparing the financial statements had been made available to and agreed by the auditors.

The Trust believes that these judgements and estimates will be resopved within the next financial year and that they fall within an acceptable range. The Trust does not believe that this presents a risk to the robustness of the accounts.